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Illinois Medical Journal

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ILLINOIS STATE MEDICAL SOCIETY
VOLUME 159, NO. 1, JANUARY 1981

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REPORT FOR *Illinois Physicians*

HEALTH CARE ISSUES AIRED AT BLUE CROSS AND BLUE SHIELD SYMPOSIUM

Nationally recognized speakers gave their views on health care issues that may develop during the 1980s at the Chicago-based Blue Cross and Blue Shield Plan's Symposium V.

More than 900 persons turned out for the day-long session at the Hyatt Regency Chicago last November. The Symposium theme was "Health Care in the '80s and Beyond . . . a Post-Election Analysis."

Speakers included Reagan Campaign Manager Sen. Paul Laxalt (R., Nev.); Citizens Party presidential candidate Barry Commoner; chief inflation fighter Alfred Kahn; and author Norman Cousins.

Also on the program were: Sen. David Durenberger (R., Minn.); medical educator John Cooper, M.D., Ph.D.; United Airlines executive Monte Lazarus; "think tank" president Willard Gaylin, M.D.; labor leader Robert Gibson; 2nd ranking Democrat on the Ways and Means Committee Rep. James Corman (D., Calif.); and community health professor Duncan Neuhauser, Ph.D.

Sen. Robert Dole (R., Kan.), incoming chairman of the Senate Finance Committee, was prevented from attending because of a budgetary conference committee meeting, but addressed the crowd by live phone hookup from Washington, D.C.

The audience included health care professionals, business executives, government and union officials and consumer representatives from throughout Illinois.

In his opening remarks, S. Martin Hickman, president of the Chicago-based Blue Cross and Blue Shield Plan, cautioned the audience against wrong expectations.

"The purpose of the Symposium is not to provide you with a blueprint for action, nor to give you the Blue Cross and Blue Shield point of view. Rather, it is to provide a forum for debate and discussion which we hope will foster a better understanding of the issues," Hickman said.

"With this line-up of speakers, we are certain that Symposium V will live up to its predecessors as a generator of enthusiasm," Hickman concluded.

John Cooper, M.D., Ph.D.

The sharpest critic of increased competition in health care was John Cooper, M.D., Ph.D., president of the American Association of Medical Colleges.

He voiced the concerns of major medical centers that medical schools may close, access to health care may be curtailed and institutions will be unable, or unwilling, to care for the indigent.

"Competition and deregulation pose a major threat to the teaching hospitals especially," Dr. Cooper said. "It is wrong to assume that hospitals provide a standard product. The teaching hospital which tends to be more expensive, provides a huge service to the community through its educational, research and tertiary care functions."

"Competition could jeopardize these functions, and the losers would be the American people, whose present health care system is the envy of the world."

"Competition is seen as a means of preventing a hospital from making too much money by providing too much care. But it is likewise true that a Health Maintenance Organization or other competitive provider can make money by doing too little."

Willard Gaylin, M.D.

Dr. Gaylin, president of the Hastings Center, pointed out that moral and ethical considerations, driven in part by the advance of technology, are the factors responsible for soaring health costs.

In bygone days, medical care consisted mainly of "care and comfort," but in recent years the acceptance of "life saving" as a goal of our society and the technology to make life saving possible have driven costs to where they are today, he said. The trend will continue, he predicted.

As a nation, "we have assumed an unlimited supply of everything. Now we find that isn't always so and we have difficulties with the facts of scarcity. We are going to have scarcity in medical care," he said.

Dr. Gaylin said that as a nation we may have to come to deal with medical care as a "communal problem" rather than on an individual basis; recognizing there is a difference between 'life saving' and 'life sustaining'. "But who's going to pull the plug?"

Sen. Robert Dole (R., Kan.)

Prevented from attending by a critical meeting of a budget conference committee, Sen. Robert Dole (R., Kan.) addressed the audience via a live telephone hookup from Washington, D.C.

He said the Reagan Administration will be quick to take up health care costs as part of its overall economic policy. "Health care has become our third largest industry, and its impact on the inflationary picture is huge. That alone puts it high on our priority list," Sen. Dole declared.

Sen. Dole predicted early Congressional action on a package of health care legislation. "You can look for a broader range of low cost health coverage featuring a high deductible. You can also expect some sort of legislation to curtail the practice of some insurers of only paying for certain medical services when provided on an inpatient basis," he said.

Sen. Paul Laxalt (R., Nev.)

"Don't look for a meat ax, look for a serious examination of what the federal government is all about."

That was the advice of President-elect Ronald Reagan's National Campaign Manager, Sen. Paul Laxalt (R., Nev.).

"We will first be looking for fat we can eliminate and, as far as health care is concerned, we will be looking hard at Medicare and Medicaid, where even prominent Democrats have estimated there is as much as $6 or $7 billion in waste and fraud," Sen. Laxalt declared.

He concluded with a promise that the first order of business in January will be "to get this physical animal that is the federal government into shape."

Alfred Kahn

Alfred Kahn, former chairman of President Carter's Council on Wage and Price Stability, announced himself as a backer of both deregulation and competition—with qualifications.

"To show you how much I favor competition, I testified in favor of Sen. Durenberger's bill—only to take a beating from my own HEW Department for doing it," Kahn quipped.

"As far as regulations go, I won't forswear the regulatory option entirely. Regulation tends to keep health care providers honest. If budget caps were placed on hospitals, I firmly believe hospitals would eliminate the unnecessary care they provide before ever cutting back on necessary care," he said.

The danger in regulation of health care, Kahn observed, is that it is difficult to construct categories of health care. "There is also the strong possibility that regulations can be used to promote monopolies, specifically use of Certificate of Need regulations to prevent the start-up of HMOs."

He urged health care professionals in the audience to approach the ideas of deregulation and competition as businessmen would.

"Try thinking about what opportunities these trends can present and what marketing approaches you should take," he said.

Sen. David Durenberger (R., Minn.)

Sen. David Durenberger (R., Minn.) viewed the November election results as a victory for competition and deregulation and he predicted that the Reagan Administration would act quickly to reduce the federal government's role in health care.

The voters were saying that they wanted less government and more individual freedom of choice. As it now stands, the federal government limits that choice by exercising its huge financial and regulatory roles,"

He said a bill he introduced in the last session of Congress would increase freedom of choice by encouraging people to remain healthy. The bill would:

- Require firms providing health care benefits to offer its employees at least three alternative health care plans.
- Require that the employer contribution be the same, no matter which plan the employee chooses.
- Limit the tax deductibility of employer contributions.

He said the Twin Cities area of his home state has made "promising beginnings" on promotion of good health and competitive health care.

"Increasing numbers of employers are granting 'wellness leave' to their employees to reward those who are on the job and not taking time off because of bad health.

"I am also excited by other trends in the Twin Cities area. Our high percentage of enrollment in HMOs and independent practice associations is giving us a chance to see what happens when a doctor actually has a chance to practice cost effective medicine. What we have seen so far is not a drop in quality, but a drop in price," Sen. Durenberger concluded.

Barry Commoner, Ph.D.

Environmentalist and Citizens Party presidnential candidate Barry Commoner warned the Symposium audience of serious consequences if the Reagan Administration is successful in its efforts to roll back regulations affecting human health and safety.

Noting that environmental measures and such legislation as the Occupational Safety and Health Act are key targets, he said such roll backs would rob the public of what little health protection it has and could expose everyone to major epidemics.

Commoner termed pollution "the environmental insult" and said the two present approaches to its elimination are ineffective.

"The regulatory approach is like slapping a Band-Aid on a wound—the damage has already been done. The Environmental Protection Agency is, in effect, trying to put the genie back in the bottle," he said.

"These environmental insults come from the way in which we produce goods, and that is why the so-called free market approach to pollution won't work. The free market is dedicated to the maximization of profits—period.

"Unless we make the general health and well-being a part of the decision on whether or not to produce goods, we will not be able to prevent environmental insults from occurring," Commoner said.

IMJ Attention

RESOLUTIONS DEADLINE—The ISMS House of Delegates Annual Meeting will convene April 5–8, 1981, at the Radisson Hotel, Chicago. Resolutions for the House of Delegates must be *received* in the ISMS offices by March 8, 1981. Resolutions received after that date will be considered late resolutions and require special action for possible consideration.

In accordance with House policy, resolutions will be published in the *Journal* by author and subject only. In order to be identified in the *Journal*, resolutions must be *received* in the ISMS offices by an earlier deadline, February 22, 1981.

JCAR VETO OVERRIDDEN—The Illinois Senate and House have voted to override Gov. Thompson's amendatory veto of House bill 2351. The veto would have removed a provision allowing the Joint Committee on Administrative Rules (JCAR) to request a binding vote by the General Assembly to prevent implementation of questionable rules promulgated by State agencies. The override, which was supported by ISMS, carried 144/24 in the House and 57/0 in the Senate.

DANGER! DOCTOR SHOPPERS—The practice of visiting one physician after another with apparently legitimate complaints in search of prescriptions for certain drugs is known colloquially as "doctor shopping". Growing reports of doctor shopping activity have prompted this notice of a special reporting system instituted by the Illinois Department of Law Enforcement (DLE). "Shoppers," DLE personnel have reported, often do not appear to be abusers. They may not show signs of drug abuse. Many simply sell the prescriptions to addict-clients.

The DLE has particularly noted diversion problems with the prescription drugs Preludin® and Dilaudid® . They report that 75mg. Preludin® tablets are typically broken down and converted to injectible form—and injected via measured dose, prepackaged insulin with attached hypodermic needle. Four milligram Dilaudid® tablets are being sold on the street for upwards of $30 each. Quaaludes® (methaqualone) continue to represent a major abuse problem, as does the drug combination of Talwin® and pyrobenzamine. Abuse of the latter combination, popularly known as "T's and Blues," caused the Illinois Dangerous Drugs Commission to regulate Talwin® (pentazocine) as a Schedule II substance. However, DLE personnel have reported, it remains a Schedule IV product under FDA regulations, and is being imported from other states—where it is not controlled—"by the bucketfuls."

An additional difficulty is that persons abusing injectable drugs and drug combinations have been known to purchase pre-packaged dosage insulin kits, which contain hypodermic syringes, over the counter. The syringes are then used to inject the illegal drug combination.

DLE staff have offered some suggestions to Illinois physicians: (1) protect your prescription pad—and report any thefts immediately; (2) if a pharmacist calls you to verify a prescription that you didn't write, don't stop with countermanding the order—report all suspected forgeries; (3) if a new patient appears to be "doctor shopping," ask who referred him or her to you. Some physicians have been unwittingly used through unsolicited referrals.

Reports and inquiries should be directed to Mr. Ben Haynes at DLE: (312) 530-3628. A special 24-hour drug diversion hotline has also been established: (312) 827-6061. Written inquiries or reports may be sent to Mr. Haynes at: Illinois Department of Law Enforcement, Division of Criminal Investigations, Drug Diversion Unit, 188 Industrial Drive, Elmhurst IL 60126.

POSITION ON FOREIGN MEDICAL STUDENTS—Based on an Illinois resolution introduced by Dr. David S. Fox, the AMA Interim Session House of Delegates adopted a resolution intended to facilitate development of a mechanism to evaluate qualifications of graduates from newly-created foreign medical schools. Adopting the position that a uniform method based in the private sector be found to evaluate foreign medical schools, the AMA House determined that standards used to evaluate foreign medical school programs should be equivalent to those by which U.S. schools are evaluated. In addition, they recommended that no individual accrediting or licensing jurisdiction act independently in making judgments on the quality of education in foreign medical schools, but rather participate in the uniform evaluation mechanism.

In reporting this action, *AM News* stated that the resolution was prompted by a plan of the New York State Board of Regents to evaluate foreign medical schools and provide hospital clerkships to foreign-trained Americans returning here to gain clinical experience. That story indicated that about 11,000 American citizens are studying medicine abroad. Most of these are enrolled in about six recently established for-profit schools in Mexico and the Caribbean which will produce a large number of students seeking clerkships beginning in June of 1981. A New York delegate stated that at least 6,000 students from New York alone are enrolled.

According to the *AM News* story and the GAO report, most of these schools do not have clinical facilities, and the Associated Medical Schools of New York has issued a position paper strongly opposing the NY Board of Regents' plan. *AM News* notes that profit-making medical schools were eliminated in the U.S. 70 years ago, after the Flexner report. Henry Gramblett, M.D., federation president, was quoted as saying that the Federation of State Medical Boards has long held that foreign schools should be held to the same standards as American schools. That group has established a national commission to assist individual state boards in evaluating foreign students' training.

AMA HOUSE ACTS ON AFP—The AMA Interim Session House of Delegates acted to oppose regulations by the Department of Health and Human Services which would regulate sale and use of maternal serum AFP (alphafetoprotein) diagnostic kits and reaffirmed objection to the use of the Medical Device Amendments of 1976 as a means of controlling the practice of medicine. After reviewing a complex report on the subject by the AMA Council on Scientific Affairs, they voted to recommend that legitimate concern for safe and effective use of AFP in the complicated testing chain required to identify fetal neural tube defects should be addressed as outlined in that report.

The Council report addresses scientific and sociological aspects of this relatively new technology, which proposed FDA regulations would limit to use by approved laboratories, with specifically designated personnel and patient demographics. The resolution was introduced by the Illinois delegation.

SSA HANDBOOK AND PAMPHLET AVAILABLE—Recent changes in the requirements for disability benefits under Title II and Title XVI of the Social Security Act were published in 1980 in a yellow handbook for physicians, "Disability Evaluation under Social Security." Objective evidence of impairments must be submitted for applicants to be considered for benefits. New diagnostic techniques and the experience of the Social Security Adminstration in the disability determination process have provided more realistic requirements for an equitable decision.

Physicians can get a free copy of these Social Security standards for disability evaluation by writing to Edward G. Ference, M.D., Supervising Medical Consultant, Bureau of Disability Adjudication Services, Department of Rehabilitation Services, Box 3842, Springfield, Illinois 62708, or by calling (217) 782-4594. A pamphlet on 1980 changes in Social Security and Supplemental Security Income disability protection that encourage beneficiaries to return to work is also available.

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Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,
Department of Radiology, Loyola University Stritch School of Medicine

This 29 year old man complains of fatigue. He has a palpable right upper quadrant mass and a hemoglobin of 7 grams.



Figure 1
Barium enema-post-evacuation. (Asterisk = extravasated barium at a site of narrowing in the ascending colon)

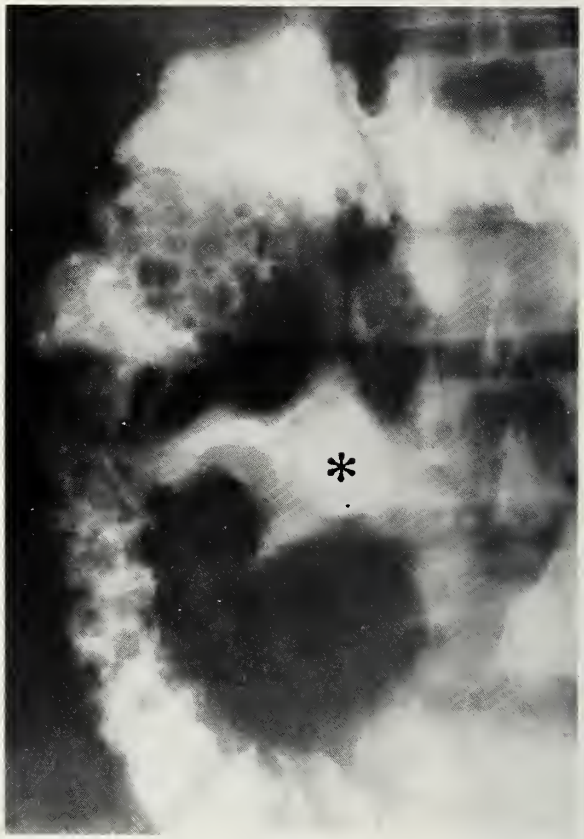


Figure 2
Close-up of hepatic flexure. (Asterisk = extravasated barium)

Your diagnosis?
(1) Diverticulitis
(2) Colon carcinoma with perforation
(3) Crohn Disease—sinus tract
(4) Traumatic colon perforation
(5) Foreign body perforation
(6) Perforation due to pericolic disease

(Continued on page 46)

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Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported: should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
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***Buttice, Gaetano T.,** Clarendon Hills, died October 26, 1980, at the age of 75. Dr. Buttice was a 1933 graduate of Loyola University Stritch School of Medicine.

***Crosson, John Wm.,** Winnetka, died October, 1980, at the age of 73. Dr. Crosson was a 1934 graduate of Temple University School of Medicine, Philadelphia.

***Donovan, Ray F.,** Watseka, died October 11, 1980, at the age of 73. Dr. Donovan was a 1933 graduate of the University of Illinois College of Medicine.

****Eisler, Edwin R.,** Chicago, died October 31, 1980, at the age of 85. Dr. Eisler was a 1919 graduate of the University of Illinois College of Medicine.

***Hickey, Thomas P.,** Kankakee, died October 31, 1980, at the age of 72.

****Kanne, Abraham S.,** Chicago, died November 3, 1980, at the age of 87. Dr. Kanne was a 1925 graduate of Chicago Medical School.

****Livingstone, Huberta M.,** Chicago, died June 30, 1980, at the age of 75. Dr. Livingstone was a 1928 graduate of the University of Iowa College of Medicine.

Lynch, John Joseph, Mt. Prospect, died October 31, 1980, at the age of 56. Dr. Lynch was a 1952 graduate of Loyola University Stritch School of Medicine.

***Murphy, Allen Francis,** Chicago, died November 12, 1980, at the age of 55. Dr. Murphy was a 1951 graduate of Loyola University Stritch School of Medicine. He also was past president of South Shore Hospital and formerly on the staff of Palos Community Hospital.

***Nakutis, Aldona Elena,** Evergreen Park, died November 12, 1980, at the age of 58. Dr. Nakutis was a 1944 graduate of *Vyteuta Didziojo University Medical.*

****Novak, Julius B.,** Chicago, died October 3, 1980, at the age of 79. Dr. Novak was a 1928 graduate of the University of Illinois College of Medicine.

****Sculley, Jesse Casstenens,** Algonquin, died November 24, 1980, at the age of 84. Dr. Sculley was a 1926 graduate of the University of Illinois College of Medicine.

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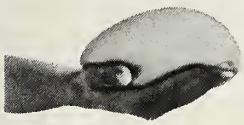




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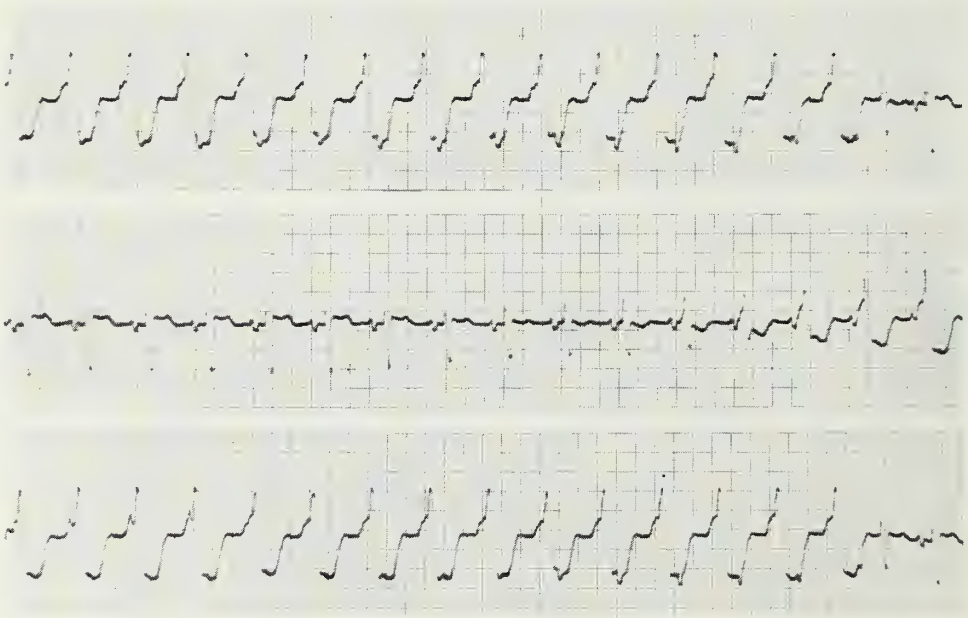
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EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a fifty-four-year-old man with a history of stable angina for two years. His angina had begun to increase in frequency two months before admission. His pains gradually increased to 12 per day. At this point he developed a more severe and prolonged chest pain accompanied by diaphoresis and nausea. The pain lasted two hours until he came to the emergency service. Morphine sulfate was required for relief of pain. He had a twelve lead ECG which showed an acute inferior wall myocardial infarction. Physical exam demonstrated an acutely ill patient who was diaphoretic with a blood pressure of 120/70mm.Hg. He was admitted to the Coronary Care Unit and ECG monitoring was begun. Approximately three hours later, the ECG rhythm strip was obtained.



Questions:

1. **The ECG rhythm strip shows:**
 - A. Paroxysmal ventricular tachycardia.
 - B. Atrioventricular dissociation.
 - C. Cycle dependent bundle branch block.
 - D. Paroxysmal atrial tachycardia with aberrant intraventricular conduction.
 - E. Paroxysmal atrial tachycardia with retrograde P waves.

2. **Treatment for this problem could include:**
 - A. Digitalis parenterally.
 - B. Procainamide parenterally.
 - C. Lidocaine intravenously.
 - D. Direct current cardioversion.
 - E. Temporary demand pacemaker.

(Continued on page 64)

Guest Editorial

Some Views on Categorization

BY MORRIS T. FRIEDELL, M.D./ CHICAGO
Chairman, ISMS Board of Trustees

In order to understand the debate over categorization of hospital medical services, one must consider historical development of the regional medical services concept. It might be said that this began with a very prominent Texas physician. From the front steps of the Houston Methodist Hospital (the headquarters of that famous heart surgeon) peripheral vision would show a small park, the M.D. Anderson Cancer Institute and the Texas Neurological Institute.

Was it this architectural arrangement that gave rise to that trio of regional services called heart, stroke and cancer? In the late fifties and early sixties, regional programs dealing with these great medical problems were strongly advocated by advisors to the federal government. The apex of heart surgery at that time combined with the proximity of the Neurological and Cancer Institute certainly had something to do with the concept. It is hard for me to believe that the locations of the three institutes constituted a preconceived plan.

In 1966, the National Academy of Sciences' publication, *Accidental Death and Disability,* stated: "The patient must be transported to the emergency department best prepared for his particular problem. In the absence of a descriptive categorization of the level of care that might reasonably be expected at a facility, neither the patient nor the ambulance driver can judge which facility is adequate to the immediate need . . . A categorization of emergency departments would serve to indicate the level of care that a patient might reasonably expect."[1]

Regionalization of medical services, with the university hospital at the apex of a broad pyramid of supporting (that is referral) systems, was a concept which appealed to planners. In that model, patients are funneled, according to the particularity and severity of their disease, to various available levels of care. BLUEPRINT FOR MEDICAL CARE[2] by Rutstein (1974) contains all the buzz words we find today—HMO, level of care, ambulatory care center, university center, the operating unit for medical care—and even an idealized concept of consultation by remote electronic mechanisms. Rutstein, who was visiting institute lecturer at Massachusetts Institute of Technology, formulated these concepts in 1970 and 1971 in a study sponsored by the Commonwealth Fund at the Institute.

The influence of the Harvard School of Public Health and the concept of the university hospital as the ideal center for treatment were not new, but were greatly enlarged by Rutstein. He predicted that HEW would become the focus of national health programs, and indeed it has. The book deals extensively with medical care facility distribution and function. It completely disregards the attitude of the patient—which is dismissed simply with, "he will have to learn," and of the physician—who will be regimented within the service. It dismisses idly the concept of a large bureaucracy necessary to administer this enormous, overblown system of medical care. Nevertheless, some ideas advocated by Rutstein and others have come to fruition in the 80's.

The American Medical Association Conference on Guidelines for the Categorization of Hospital Emergency Capabilities said in 1971: "The basic purpose of categorization is to identify

MORRIS T. FRIEDELL, M.D., is chairman of the ISMS Board of Trustees. A board certified surgeon, he is also chairman of the board at the Hektoen Institute for Medical Research, president of the Jackson Park Hospital Foundation and a professor of surgery at the Chicago Medical School. He is former editor-in-chief of *International Surgery* and a member of numerous professional groups.

TABLE 1

Advantages of Categorization

1. Availability of classification of services of various specialties.
2. Lay people and public agencies will have information as to what services are available.
3. Physicians may want to use this information for referral of patients.
4.. Allows easy bureaucratic recognition of centers eligible for grants and funding with less regard for quality.

Disadvantages of Categorization

1. Development of a rigid system which stifles the initiative of the individual.
2. Use of voluntary standards to establish rigid governmental and bureaucratic criteria for delivery of services.
3. A vehicle for discrimination of funding so that, for instance, perinatal Level III services only are funded by Federal funds although Level II perinatal services are almost as expensive.
4. Categorization is almost the opposite of fee for service practice.
5. Categorization is part of a regional health service program which allows bureaucratic organization of medical services with complete disregard to the needs and feelings of either the patient or the physician.

the readiness and capabilities of the hospital and its entire staff to receive and treat, correctly and expeditiously, emergency patients. Ambulance personnel, law enforcement officers and other citizens of the area, having advance knowledge of the designated categories of emergency capabilities of the various hospitals in the area, may thus select the proper institution to which emergent patients should be taken."[1]

Categorization of emergency medical services began with various classifications—such as comprehensive, basic, major, primary, elementary—and evolved to more sophisticated trauma and burn units. Paramedical involvement in emergency systems with remote telemetry, capability for administration of IV medication, intra-tracheal or other airway maintenance, have become the vogue. The cost effectiveness of these systems has not been entirely worked out. Instant communication with medical facilities allows for more appropriate distribution of emergency patients to hospital emergency rooms which are not too far away from the site of the catastrophe and are capable of at least managing the most severe life threatening situation. Nevertheless, there have been impositions on this system which appear to be irrelevant—such as transfer of burn victims by helicopter merely because there is a fire department helicopter available. Considerations for availability of beds and skilled medical service generally have not been fully implemented.

It is assumed that a university center would have continuously available trained personnel to handle most emergencies. This has raised the question of whether a first or second year resident is considered equivalent to a skilled, experienced orthopedic surgeon, who may be a few minutes further away from the emergency room. And now we hear of the so-called "centers of excellence," which may be confused with the "center of everything," as though quantity is equivalent to ability and more is always better.

With the development of the emergency physician specialty a new concept in emergency room management has arisen.[3] The availability of a skilled physician trained in emergency medicine has apparently affected the categorization idea of the emergency room to some extent. How far this will affect the Joint Commission standards is hard to tell, but it is evident that the AMA's report on emergency room classifications and needs (GUIDELINES FOR CATEGORIZATION OF HOSPITAL EMERGENCY CAPABILITIES: AMERICAN MEDICAL ASSOCIATION COMMISSION ON EMERGENCY MEDICAL SERVICES) will undergo extensive revision because of the influence of the American College of Emergency Physicians.[4]

With some of these concepts in mind, categorization has been extended to a numbers game by government agencies and bureaucrats. For example, after initial conference by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology, a standard of 1500 deliveries per year was established as minimum for an obstetrical service. In the meantime, obstetrical and perinatal services were classified as Level I, Level II and Level III, with Level III as the most complicated and most technical set-up. Attempts are now being made to discourage the

continuance of obstetrical services at hospitals which have fewer than 1500 deliveries per year; a situation which cannot be encountered in rural or in small community hospitals.[5]

Another attempt at categorization arose when the designations "primary, secondary and tertiary," were used to classify hospitals. Discrepancies develop when a "tertiary" hospital is supposed to have all the skilled services, but in fact, a community hospital may have a highly skilled person who delivers an advanced technical service in a smaller setting. This could occur in a designation of plastic surgery center, or ophthalmology center because a skilled plastic surgeon or an ophthalmologist who has developed a unique technic is present. To meet this dilemma the designation of vertical categorization was created.

Willemain[6] constructed a mathematical model in which he used only two classes or categories of emergency room facilities: (1) definitive care facility and (2) stabilization facility. This latter model may more suitably describe services that are needed for emergent patients. His paper attempted to relate this to dollar cost. It is important to establish a mix of facilities, both with regard to special relationships and population as well as facility density. A facility categorization of stabilization versus definitive care would then allow only two categories for emergent patients. A question for the Medical Society to determine is whether a facility capable only of stabilization with rather limited or major capacities in only a few areas, (so-called vertical abilities) should be maintained as opposed to a comprehensive facility which provides definitive care in all areas.

The Joint Commission on Accreditation of Hospitals seized upon the need for categorization of emergency rooms and developed a series of standards which have become more rigid by the year. Unfortunately, it did not have enough expertise to inspect emergency rooms and to establish qualifications on a basis which was meaningful. At the last convention of the American Medical Association House of Delegates, (July, 1980) the Joint Commission agreed to review its standards on categorization and to change its inspection methods so that criteria would be more meaningful and less rigid and the need for more skilled and trained inspectors was acknowledged. No one argues that these are not desirable ends, but the methods of achieving them have not quite come to the expected fruition. The problem, of course, deals with triage, that is, selection of the appropriate site for the patient. Naturally, selection will favor those emergency rooms which are recognized to be the most comprehensive, regardless of the service needed.

Since these two statements have been made, triage has become a matter of communication basically between paramedics and other official rescue bodies and communication centers by use of telemetry and other means. The problem of triage remains, however, and is not entirely solved by these means. (An additional concern is the opportunity now offered to regional planners to utilize physician extenders and allied health practitioners as the entry level to regular medical care, much as paramedics serve as the entry level to emergency medical care).

In addition, hospitals may provide an uneven level of service; some may have burn centers and others may have skilled orthopedic facilities; in a third an ophthalmologic surgeon may have reached a degree of excellence for a specific injury. The problem of categorization in these cases is that it tends to transfer the quality of medical care from the physician staff available to the comprehensiveness of the institution. This may not be a desirable end and should certainly be the subject of intense review by the Medical Society. Up to now, institutions have adopted these criteria voluntarily, except that official designation of trauma centers appears to be established in Illinois (without apparent input from the Medical Society). The criteria for and designation of a trauma center have not, to my knowledge, been reviewed by the Medical Society.

Willemain[6] concludes that regional categorization of emergency facilities by care capability within diagnostic classes is a major thrust of current emergency medical service planning. This is motivated both by financial and clinical considerations and is intended to better match emergency care resources to public demands. However well intended, the process is a complicated one and not yet fully supported by theory and data. It should be noted that, as Willemain states, "categorization is a device to establish regionalization of the delivery of medical care."

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A Review

Sleep, Physiology And Disorders

By Abd El Aziz A. Salama, M.D./Springfield

In the past 25 years, study of sleep mechanisms has developed rapidly and become a major field in neurophysiological research. This rapid growth is due in part to some discoveries which have changed the classical neurophysiological picture of sleep from the concept of a passive resting state of the brain to that of a heterogeneous and complicated succession of active phenomena.

Sleep has been a problem since the creation of mankind. Hippocrates mentioned the case of a woman from Thesus with melancholia who "became affected with loss of sleep." Five hundred years later, Arataeus (120-180 A.D.) described depressed patients as "sad, dismayed and sleepless, who became thin with their agitation and loss of refreshing sleep."

Freud opened up the area of the importance of dream content, and for the past 60 years this has played an important part in psychiatric theory and practice. However, only recently has the average psychiatrist become aware of the importance of sleep.

The field of sleep study represents a rapidly advancing frontier, with application not only for treatment of everyday tension, but also for psychiatric illness and the entire field of medicine.

ABD EL AZIZ A. SALAMA, M.D., is a board certified psychiatrist and assistant professor of psychiatry at the SIU School of Medicine in Springfield. Dr. Salama is diplomat of the Royal College of Physicians and Surgeons of England in Psychiatry and Neurology and a member of the Royal College of Psychiatrists. He holds membership also in the American Psychiatric Association, American Medical Association and corresponding Illinois groups.

What Is Sleep?

Sleep is a recurring state of inactivity accompanied by lost awareness and decreased responsiveness to the environment. Sleep is distinguished from coma due to disease, drugs, or alcohol and from unconsciousness caused by general anesthesia by the ease with which the sleeping subject can be roused to awareness of the surrounding world.

Stupor, on the other hand, is also associated with unresponsiveness and immobility, but the disorder is one of motility, not consciousness, for the stuporose patient is fully aware of the environment, although unresponsive. There are a number of conditions of dissociated consciousness, such as hypnotic trances and fugue states. These are intermediate and possess some of the features of both sleep and wakefulness. However, the affected individual, although amnesic for his or her actions, behaves for the most part as if fully alert and in touch with the external world.

Hypersomnia has been defined by Kleitman[1] as "uncontrollable somnolence and pathologically prolonged sleep, from which it is sometimes diffi-

cult to arouse the sleeper, or to keep him awake for any length of time after he has been awakened."

Physiology of Sleep

Polygraphic studies of EEG and EMG of noctural sleep were pioneered by Aserinsky and Kleitman[2] and Dement and Kleitman.[3] There are two states of sleep, and these are opposing states:

NREM (non-rapid eye movement sleep): The EEG pattern consists of a background of slow waves with superimposed bursts of 12-14Hz spindles and K complexes. (These are transient high voltage slow wave complexes occurring both spontaneously and in response to potentially alerting stimuli.) There is a slow eyeball oscillation during drowsiness prior to deep sleep and in the lightest stages of NREM sleep. Cardio-respiratory activity is steady, with slower heart and respiratory rates than during quiet waking. The skeletal musculature is greatly but not completely relaxed, so EMG activity of wakefulness continues in this slow wave sleep. Upon awakening in this state, subjects are likely to report that they were "thinking."

REM (rapid eye movement sleep): bursts of rapid conjugate eye movements which are accompanied by a low voltage mixed frequency EEG pattern and complete muscle relaxation, especially profound in neck muscles. Cerebral blood flow is greater than during waking hours. Heart rate, respiration and blood pressure become highly variable with high mean levels. The penis is in a state of tumescence. When awakened from REM sleep, the subject is likely to report vivid dreams with much visual imagery.

In normal circumstances, REM sleep is always preceded by NREM sleep, and both states alternate in more or less predictable sequence. Dream recall has been reported in more than 70% of persons wakening from REM sleep.

The term "stage" usually refers to a relatively precise but arbitrary subdivision in the course of the continously progressing change.

However, with regard to NREM sleep, only four stages are commonly accepted as subdivisions. These are the EEG stages of NREM sleep:

Stage 1: A relatively low voltage mixed frequency.

Stage 2: K complexes and 12-14Hz sleep spindles on a background of stage 1.

Stage 3: Moderate amounts of high amplitude slow wave activity, with about 50% of waves of 2Hz or less.

Stage 4: Large amounts of high amplitude activity with more than 50% of waves of 2Hz or less.

Some degree of mental activity can be recalled during NREM wakenings, but this lacks the vivid hallucinatory quality of dreams.

In REM sleep, the forebrain appears to be aroused; there is EEG activation and elevated brain temperature. There is also the process of tonic motor inhibition which is measured by recordings of the electromyogram of the neck muscles (especially the digastric muscles). There are many muscles which are not continuously inhibited during REM sleep. This include the diaphragm, the extraoccular muscles, the middle ear muscles, the intercostal muscles, some muscles of the face, the nasopharynx and larynx.

A Healthy Person's Sleep

First there is drowsiness, increased muscle relaxation, slow eyeball oscillation, and disappearance of the alpha rhythm. This is followed rapidly by NREM sleep. Stage 4 is reached within 30-60 minutes, interrupted after 90 minutes by sudden appearance of REM sleep for 5-10 minutes. There are four to six REM periods during the night, alternating with NREM sleep; each lasts for 10-30 minutes, accounting for 80-100 minutes of REM sleep, the longer periods of which are the late ones.

So, of the usual 6.5-8 hours of sleep of a young adult, 20-25% is spent in REM, 5% in stage 1, 50% in stage 2, 7-8% in stage 3, and 3-16% in stage 4.

REM sleep is much more abundant in neonates (about 50% of their sleeping time). It decreases progressively after birth, until the end of the first year. It is 20-25% until adult life.

Most psychoactive drugs suppress REM sleep, few increase it as with the use of MAOI and benzodiazepine derivatives.

Location

NREM sleep center is located in the preoptic region of the hypothalamus, lower pons and medulla.

REM sleep center is located in the nucleus reticularis pontis caudalis.

Wakefulness is maintained by tonic discharge of the reticular activating system in the tegmentum and posterior hypothalamus.

Biochemistry of Sleep

This started with Jouvet (1967).[4] He found that depletion of nomoamines leads to the disappearance of the state of sleep and that this effect was reversed by both 5-hydroxytryptophan (a precursor of serotinin) and by L-Dopa (a precursor of dopamine and noradrenaline).

Clinical Sleep Disorders

The four major categories are (1) Primary sleep disorders, (2) Secondary sleep disorders, (3) Parasomnias and (4) Sleep-modified disorders. These will be approached separately.

Primary Sleep Disorders

Insomnia—Insomnia, one of the most common sleep disorders, is characterized by inability to fall asleep, frequent and prolonged awakenings, and early morning awakenings, all in the absence of gross physical or psychological pathology. Recent EEG sleep studies indicate that there is a physiological basis for the insomniac's complaint. Karacan, *et al.*[5] have found these patients to have significantly longer sleep latencies, shorter sleep times, and less efficient sleep. Insomnia affects 14% of the population. About 15% of men and 25% of women over 45 years of age take hypnotics. Poor sleepers take longer time to fall asleep, have nocturnal awakenings and more of stage 2 and less REM sleep than good sleepers, but both spend equal times in stages 3 and 4 of NREM. Poor sleepers also exhibit heightened physiological arousal with faster heart rates, peripheral vasoconstriction and higher rectal temperature. MMPI showed poor sleepers to be more anxious, depressed, and with more peculiarities of thought. The short sleepers are described as those who sleep less than 6.5 hours per night, who tended to be successful, well adjusted, with little psychopathology, as they avoid psychological problems rather than facing them. Longer sleepers tended to be worriers, shy, mildly depressed, anxious, neurasthenic and with mild psychosomatic complaints.

The most common complaint is difficulty in falling asleep. It accounts for 80% of patients suffering from insomnia. Difficulty in staying asleep and early morning wakenings are less frequent.

The Narcoleptic Syndrome—A full blown form of syndromes involves a tetrad of symptoms.

NARCOLEPSY—This consists of irresistible attacks of apparently natural sleep, which generally occur suddenly and usually last about 15 minutes. The patient can be aroused easily as from normal sleep. The sleep attacks are most likely to occur after meals or at times of boredom or inactivity or, in some patients, during activity, after which patients usually awaken refreshed and there is a refractory period of 1-5 hours before the next episode.

The incidence of narcolepsy has been estimated at 0.2-0.3% of the population in a study in Germany by Reding, *et al.*[6] However, the syndrome may be more prevalent than was once suspected, since many cases probably continue to be misdiagnosed as epilepsy, hypoglycemia or hypothyroidism. In every case, a neuropsychiatric evaluation, an EEG examination, blood sugar, hormonal tests, and skull X-rays should be done prior to prescription of antinarcoleptic agents.

Most sleep EEG research on the narcoleptic syndrome has attempted to relate the disorder to the REM state. Roth, *et al.*,[7] did a study on narcoleptics and controls and stated that in normals the various stages of sleep occur in a regularly recurring, clinical fashion: NREM sleep occurs first, with REM appearing after about 60-90 minutes of NREM sleep. Thereafter, REM and NREM alternate cyclically throughout the night. In many narcoleptics, REM occurs at, or soon after, the onset of sleep.

CATAPLEXY—In this condition there is a sudden decrease or abrupt loss of muscle tone, either generalized or limited to certain muscle groups; ranging from transient weakness of the jaw to complete muscle atonia which results in a sudden slump to the ground. Deep tendon reflexes are lost and the plantar reflex is absent. Attacks occur in clear consciousness and are transient, lasting only a few seconds. It is often precipitated by emotion, as in laughter, anger, excitement or surprise. It may occur many times a day. In this condition, there is dissociation between the peripheral and central manifestations of REM sleep. The biochemistry and pharmacological treatment of narcolepsy are still largely unexplored areas.

SLEEP PARALYSIS—This is a sudden flacid muscular paralysis with total inability to move which occurs in full consciusness, either while the subject is falling asleep or on waking from sleep. It is often accompanied by an intense feeling of fear and by hypnagogic hallucinations. It is possible to terminate the attacks by touching the patient. As an isolated disorder, it has been found to occur in from 2% to 15% of people in a study by Goode.[8] It appears to predominate in males, and there is occasionally a family history. Sleep paralysis episodes occurring in narcoleptics seem to occur during sleep-onset REM periods.[9]

HYPNAGOGIC HALLUCINATIONS—There are vivid auditory and/or visual hallucinations, often with a frightening or terrifying quality, which occur during waking periods, immediately before sleep. If after sleep, it is called "hypnapompic hallucinations." These are said to be dream experiences of REM sleep onset.

Any of the four cardinal symptoms of the narcoleptic syndrome can occur alone or in combination with any or all of the others. Narcolepsy

alone is usually a lifelong disorder, starting in between 10-20 years of age.

Narcolepsy with capaplexy has been described in association with multiple sclerosis, frontal lobe meningioma and epidemic encephalitis.

A more definite metabolic finding in narcoleptic patients is a high prevalence of diabetogenic hyperinsulinism and obesity.

The Hypersomnias: These are conditions characterized by a tendency to sleep for excessively long periods, either as an extension of nocturnal sleep into the late morning or past noon, or at various times during normal hours of wakefulness. Sleep does not refresh the patient. It occurs during the NREM sleep. It could be either chronic or periodic.

A chronic tendency to sleep excessively may be associated with various disorders of the central nervous system, such as trauma to the skull, cerebrovascular disorders, brain tumors, or without any underlying pathological lesion.

Periodic hypersomnia includes both the Kleine-Levin and Pickwickian Syndromes.

Critchley[10] reported the chief characteristic of the Kleine-Levine Syndrome to be "periodic hypersomnia, marked hunger and megaphagia in adolescent males." He added that in "genuine" cases the attacks first appear during adolescence and occur periodically at about six month intervals. Each attack lasts for days or weeks and eventually disappears spontaneously. The onset is sudden, with irritable sleep and a vivid dream content for more than 18 hours per day. Patient is always rousable and wakes spontaneously to attend to toilet needs. He may suffer a fever of 100°F, irritability, restlessness, depersonalization, difficulty in thinking, disorientation, with impairment of memory and time judgment. There are also vivid waking fantasies, sometimes difficult to distinguish from dreams. Episodes of somnolence and bulimia may be initiated by a period of hunger and a feeling of coldness lasting several days, to be followed by a depressive feeling, with self-depreciation, guilt, suicidal ideas and retardation. This condition has to be differentiated from hyperphagia due to lesions of the ventromedial hypothalamic nuclei and cases of somnolence due to lesions of the posterior hypothalamic region. Duffy and Dawson[11] reported finding a female case.

Burwell et al[12] first defined the Pickwickian Syndrome as a condition characterized by "obesity, ravenous appetite, impaired respiration, fainting and an often irresistable tendency to fall asleep." Drachman and Gumnit[13] stated that apneic intervals lasting from 5-60 seconds begin to appear very soon after the Pickwickian patient obtains over 10 hours of sleep within 24 hours.

Secondary Sleep Disorders

Secondary sleep disorders are the conditions in which chronic clinical problems are accompanied by specific or nonspecific sleep disturbances.

Functional Psychiatric Illnesses—Most investigators agree that depressed patients have less total sleep time, less slow-wave sleep, and more awakenings during the night than normal subjects. The greatest sleep disturbance is during the last third of the night in depressives and early morning waking in both manics and depressed. There is decreased REM sleep during the most severe stages of the illness, followed by an increase in this stage during the period of clinical improvement.

In schizophrenia, there is a consistent finding of delayed sleep onset, with an intrusion of the REM state into wakefulness.[14] Kupfer, *et al.*,[15] reported significantly reduced REM time in acute schizophrenics in the early part of their illness.

Alcoholic Psychoses—Slow-wave sleep and REM sleep appear to be suppressed during acute alcoholic episodes.[16] Initially there is an increase in slow-wave activity and a decrease in REM. Later, both may disappear completely. Complete suppression of REM may be the precipitator of an alcoholic seizure. Withdrawal of alcohol is accompanied by rebounds of both slow-wave and REM sleep. The REM rebound may provide the basis of the hallucinations characteristic of alcohol withdrawal.

Metabolic and Nutritional Disorders—Patients suffering from uremia have been noted to experience insomnia at night. When treated with renal hemodialysis, the various aspects of their sleep patterns showed marked improvement.

Hypothyroid patients showed reduction in stages 3 and 4 sleep; when treated, these stages improved toward normal level.

Patients suffering from anexoria nervosa showed decreased total sleep time. Their sleep patterns are more closely related to changes in nutritional status, especially due to starvation, than to changes in emotional state.

The same happens with starvation, hyperthermia and during the first trimester in pregnant women.

Organic Disorders—In lesions involving the mid-brain tegmentum or posterior hypothalamus, NREM sleep is depressed. Involvement of the preoptic area of the anterior hypothalamus causes insomnia. Bilateral stereotactic thalamotomy gives low voltage EEG and insomnia.

In African Trypanosomiasis (sleeping sickness), EEG of patients showed suppression of vertex sharp waves, K complexes and sleep spindles.

In some demented patients, episodes of nocturnal agitation and confusion were noticed when awakened from REM sleep.

The Parasomnias

The parasomnia phenomenon describes those conditions in which activity similar to waking behavior appears during sleep.

Somnambulism (sleep walking)—This is not uncommon in children, predominantly in males, 15% between 5-15 years, and quite often accompanied by enuresis and/or night terrors. There is always a positive family history. It typically occurs during slow-wave sleep.[9] The sleep walker is in a trance-like state, displaying investigatory eye movements with poor motor coordination and a low level of awareness. His movements are rigid, repetitive and purposeless.

Somniloquy (sleep talking)—Appears to be quite common, whether as an isolated phenomenon or as an accompaniment to other sleep, psychopathological or organic disorders. It usually accompanies body movements and occurs predominantly during NREM sleep and in some individuals during REM sleep. Arkin, *et al.*,[17] have found high concordance between content of sleep talking and content elicited on awakening from REM sleep-talking episodes.

Pavor Nocturnus (night terrors)—Occurs in 3% of healthy children, either as night terrors or as dream anxiety attacks. Both occur in all ages and cultures. Dream anxiety attacks are generally much milder than night terrors and occur following a well-developed dream sequence during REM sleep. Night terrors occur in the first NREM period, in the first 90 minutes of sleep. In one-third of cases, there is sleep walking, often with violent movements. All subjects are also sleep talkers.

Nocturnal Enuresis—This refers to bedwetting in children old enough to have acquired control of micturition. It is the most frequent childhood sleep disorder. It predominates in males, and sometimes there is a family history of the disorder. It occurs in 3.6% of boys and less than 2% of girls in the 10-11 year age group. Bedwetting typically occurs during slow-wave sleep. Broughton[9] has suggested that enuresis is also a slow-wave sleep arousal phenomenon, as are sleep walking and night terrors. Etiological theories of enuresis are numerous and varied. It could be genetic, habit deficiency, pathological or psychological.

Bruxism (Nocturnal teeth grinding)—Diurnal and nocturnal teeth grinding are separate phenomena.[6] During the day it is called bruxomania, as a part of oral gratification. Severe bruxism may occur during the period of separation or acute stress. It could also be an expression of anger. Males seem to be more affected, and up to 15% of individuals in a survey gave a history of bruxism. It occurs primarily during stage 2 sleep. Reding, *et al.*,[6] have proposed that bruxism is a partial arousal phenomenon. Other factors could be found as in dental conditions, lesions of the brain stem, or due to psychological factors.

Sleep-Modified Disorders

These are clinical syndromes which are aggravated during sleep. The five most important are described below.

Ischemic heart disease—Nocturnal angina pain attacks appear to occur predominantly during REM sleep.[18] Myocardial infarction frequently occurs during sleep.

Emphysema—Abnormal increase in alveolar CO_2 tension and decrease in arterial O_2 saturation during sleep may contribute to these patients' post-awakening difficulties.[19]

Bronchial Asthma—Typical asthmatic attacks are at night. In children, attacks are confined to the last two-thirds of the night, while in adults they occur throughout the night.

Duodenal ulcer—The high nocturnal secretion rate of gastric acid is particularly exaggerated during REM sleep.[20]

Epilepsy—EEG studies showed more abnormal waves during sleep than during the waking state in known epileptics, particularly in patients with psychomotor epilepsy.[21]

Several other medical disorders interfere with the sleep pattern and these include: neuromuscular disorders, metabolic disorders and parasitic infestation.

Treatment for Insomnia

Kales and Gary[22] evaluated the effectivensss of psychotherapy, pharmacological treatment and a combination of both. They found that depressive patterns increase with age. Depression in the younger age group appears to be qualitatively different from that in the older age group. The type of sleep problem (falling asleep, staying asleep, or early awakening) also was related to age. The use of drugs appeared to be much more strongly related to age than to type of psychopathology. Drug usage was strongly related to increasing age.

The same evaluators[23] studied the following drugs and their average doses: (1) Chloral Hy-

drate (Noctec) 250-500mg.; (2) Secobarbital (Seconal) 100mg., (3) Glutethimide (Doriden); (4) Methaqualone (Sopor) 150-300mg.; and (5) Flurazepam (Dalmane) 30mg.

They found that all of the drugs were initially moderately to markedly effective in inducing or maintaining sleep, or both. Also, they found that by the end of a two week period of drug administration, decreased effectiveness had developed with all these drugs except flurazepam.

They also added that many of these patients were seen in an ongoing psychodynamically oriented psychotherapy, some for two to three years.

Based on their theory, flurazepam is the drug of choice in all insomniac patients, whether they have a significant difficulty either in falling asleep or staying asleep or both. For most patients, treatment is initiated with a 15mg. dose at bedtime. Dosage is increased to 30mg. if no response is elicited within one week.

Treatment for Narcolepsy

Several drugs were used, including Levoamphetamine 60mg./d. Methylphenidate 80mg./d. for catalepsy, Imipramine 75mg./d. or chlorimipramine 25mg. B.I.D. (Anafranil).

Yoshihiro, *et al.*,[24] treated four patients with narcolepsy and periodic somnolence in which manifestations such as sleep attacks, cataplexy, hypnagogic hallucinations and sleep paralysis were markedly improved with ergotamine tartarate only. They added that although ergotamine has generally been believed to be in all likelihood devoid of significant effects on the CNS (except its activity of stimulating the vomiting center), it may be conceivable that ergotamine or its metabolites interferes with serotinin metabolism in the brain of narcoleptics, given its noticeable structural similarity to its competitive analogue, LSD. Treatment of night terror was effective with diazepam. Imipramine was used with success with nocturnal enuresis and Chlorimipramine in cases suffering the Pickwickian syndrome. Hypnotherapy is said to show partial success with bruxism. ◀

References

A complete list of references for "Sleep, Physiology and Disorders: A Review," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.



Special Articles

A Study

Coping With An Impotent Husband

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What is it like for a woman to marry and not be sexually approached by her husband? What changes occur in a relationship where previously she was avoiding sex while he was demanding it daily, but slowly he begins to avoid her? Does she worry, feel relief, suspect a rival, think he has rejected her, or feel concern about his physical health when impotence is recurrent? Do some women feel that this means he really may be homosexual?

All of these thoughts and more torment the wife of an impotent man. One 40-year-old woman said: "I feel like the loneliest person in the whole world. This is not something I can tell anyone. I could not talk to him, he was more upset than I was. I hoped it would go away. There were nights I just couldn't sleep. I would reach over and it seemed he would withdraw from me even in his sleep. I worried that I had done something, that it was my fault." This history emerged when she was seen for a clinical depression. By then the impotence was of 6 years duration. Is this an isolated or unusual reaction? It may not be.

From a study of the wives of impotent men, it appears this is a special group of women who need recognition and assistance by physicians. Their unexpressed problem may masquerade as the depression described above or a variety of other complaints such as: persistent backache; chronic headache; continuous lower abdominal pain; chronic vaginitis, etc., all with an absence of detected physical signs or positive tests. It is only when finally the physician sits down to ask a few questions about sexual function that the causative factor of a husband's impotence may surface, to be discussed and possibly dealt with.

This may take time, which the physician may not have at that moment. However, to acknowledge the problem as worthy of discussion, schedule a next appointment, telling the patient: "This is important and we must have some more time for discussion. Let me give you a Monday, 4:30 p.m., appointment so we can have half an hour to talk. Meantime, you make some notes: When John's impotence started; how often he was impotent; was he drinking; is he now on medication and what; what you have done about it, so we can try to understand where to go from here. Impotence is a treatable condition today."

At the Loyola University Sex Clinic a study was done of 151 wives of impotent men. During a seven year period, 151/398 men who presented with their wives for sex therapy had the symptom of impotence. The structure of this medical school training program is to treat a couple once a week for seven weeks by a dual trainee sex team under close faculty (on site) supervision. The couple is seen for 35 hours in those seven weeks; there is an intensity and depth, which may contribute to therapeutic success of the modality. Findings from the study of the 151 wives may help to alert the practicing physician to the mosaic of human situations underlying the clinical symptom of impotence, both for a male who presents individually or his wife, who may mention his problem in an attempt to get help for them both.

94/151 (62%) of the wives reported sexual problems: 12 primary anorgasmia; 50 secondary/situational anorgasmia; nine vaginismus; one dyspareunia when infrequent attempts at intercourse were made; 22/94 (24%) reported the symptom or complaint of: "no interest in sex

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anymore;" 57/151 (38%) of the wives were free of sexual symptoms.

In only 12/94 (8%) of the symptomatic wives, did their sexual problem (primary anorgasmia) *precede* the impotence. The other 82 symptomatic women related the onset of their sexual difficulty to that of their partners.

57 (37%) of the 151 men had attempted intercourse with one or more other women (10 of the 57 had gone to a prostitute). Of these 57, 14 (24%) said they were "fine" with other women, four said they were sometimes impotent with another woman and 39/57 (68%) said they were impotent with their liaison partner as well. 97 of the 151 impotent men, (64%) said they were too anxious about their performance to attempt sex with someone else.

Of the wives, 23/151 (15%) had attempted an affair. Most of these 23 reported, "It was great for my ego" although 10/23 said they had anorgasmia with the outside partner. Successful casual sex appeared to be as difficult for them as for the 39 impotent men who had unsuccessfully tried a liaison. In only eight (5%) of these 151 marriages did *both* partners have extra-marital contact, initially secretly but later revealed to each other.

Duration of the impotence had ranged from eight months in one to 21 years in another. For most of the 151 men their impotence had been a problem for 2-10 years before they sought help. Seven of the 151 were cases of primary impotence in unconsumated marriages of duration ranging from eight months to eight years. It is interesting to note that 58/151 (38%) men started out with the initial sexual symptom of premature ejaculation. Impotence came later and seemed to develop as a secondary symptom defending against the initial premature ejaculation symptom. The initial problem may have caused so much anxiety about control as to finally paralyze the penis into total non-function. In three men, their presenting complaint at the Sex Clinic was "lack of sex interest." It was only from a thorough and explicit sexual history that the sexual sequence was revealed: premature ejaculation, secondary impotence then lack of desire: a "giving-up syndrome," and maybe an easier complaint to acknowledge to self and to others than impotence.

For the 26 wives who presented with lack of desire, all related this symptom to years of futile struggle to achieve successful coitus, feeling rejected, sexually unattractive and finally culminating in sexplay avoidance "to prevent frustration." In none of the 151 impotent men, at the time they reached Loyola Sex Clinic, was there any consistent altruistic pattern of meeting the wife's sexual needs by kissing, caressing, manual or oral genital stimulation. In his own pain, loss of prowess, performance anxiety, shame, anger at self, self-blame or projected blame at the wife, each impotent man seemed to be unable to obtain vicarious sexual satisfaction by participating in his partner's arousal and climax.

In the group of 151 wives, 32 (21%) could be accurately described as angry, demanding, depreciating and domineering. Seven of these wives dropped out of treatment in the first month saying in effect: "Fix him—he's the patient." However, the majority of the wives—119/151 (79%) were *not* rejecting or blaming. They were supportive, sensitive and concerned.

At first it appeared clinically useful to divide the marriages into conflictual and non-conflictual. This may more easily be done when the conflict is blatant. However, the division is less accurate when the hostility is camouflaged by denial or by good social skills which may present a facade of harmony. Also, it was often difficult or even impossible to make a retrospective assay of which came first: conflict or sex problem. Often the attempt to categorize the relationship (conflictual/not) was merely academic rather than clinically or even prognostically helpful in treatment outcome. Sometimes the most vehemently conflictual couple showed excellent cooperation and symptom reversal in less than the allotted seven weeks. Others, however, who appeared superficially cordial and verbally agreed to cooperate in treatment, (yet pleasantly avoided suggested home loveplay which is an essential part of sex therapy)—retained their sexual symptom. There seemed to be a hidden agenda of "help us but don't change us!"

When couples comply and do their loveplay for a few weeks at home, the enjoyment and closeness can rapidly undo years of confusion and tension. Surprisingly, even sensual (rather than specifically genital) caressing may stimulate erotic erections not experienced in many years. A 65-year-old who was skeptical of face caressing and kissing experienced from this his first full erection in seven years. One wife, said: "No man with hands or mouth needs to be impotent—I'm so lucky, I (. . . achieve orgasm . . .) in about five minutes. It's been almost eleven years since we had intercourse. Perhaps it's 15 years ago since he touched my body. I used to masturbate in secret. For the last two years I do it in bed, he lies there pretending to be asleep but I know he's not—He says nothing about sex or the lack of it. This is worse than being brother and sister, because I feel so bottled up, like I may explode one

day. Why won't he even talk about it?" The barrier and the burden of sexual silence was indeed painful for this woman who wept as she told her story for the first time at age 42.

We found it helpful to divide wives of impotent men into two groups: the unfaithful and the faithful. The choice of these terms was descriptive, not moralistic. It helped us to evaluate what personal solutions had been tried, how these had worked and, what commitment she had to preserving marriage now. It was particularly helpful in clarifying the actual presenting complaint to the doctor and answering our query: "*why now?*" 125 of the 151 couples presented because they had read about or seen TV programs about the Loyola Sex Clinic. 26 were referred by their doctor. In 32/151 couples, the wives said they would divorce unless the sex problem was reversed, thus interpersonal pressure on the husband precipitated the search for treatment. In 78/151 the men made the initial contact with the clinic. In 70 the wife called first, saying the husband would also call, and he did. In three cases, the wife was the only one who called; the husband complied in coming to the clinic. One of these three was an extremely passive man who followed every given instruction and suprisingly reversed the impotence within five weeks, with marked animation and satisfaction for both. However, two of the three men who had not confirmed the telephone intake came resentfully, apparently unable to refuse openly. However, for each of these two men (as for a number of others) there was private masturbatory potency, but in the couples' conflictual interactions, the selective impotence was clearly a retaliatory withholding pattern. In the vernacular, the underlying message was "I can screw you by *not* screwing you----"

Of the 7/151 wives who discontinued within the first month, three were currently involved in a secret affair. (Three husbands also dropped out of treatment in week two for the same secret reason. They were potent elsewhere by choice.) Four of the women who dropped out said they had "better things to do" and it was "not my problem." Their husbands completed seven weeks of treatment as solo patients. A fourth husband dropped out in week three (primary impotence in an unconsummated marriage.) He was a brittle, anxious "workaholic" who accepted a referral for artificial insemination to meet his wife's demands for a child, which later was so conceived. A total of 140/151 wives completed the seven weeks of treatment with their husbands. Symptom outcome for the impotence showed: nine total failures (the four dropout husbands were included here); 28 partial failures (potent with masturbation but no intercourse was attempted by week seven of treatment nor were followup forms returned.) Therefore, our failures for the males totalled 37/151 (24.5%). For the 94 symptomatic wives 87 (92%) reversed their symptoms, and seven (8%) remained symptomatic, a significantly lower failure rate than for their husbands.

The new brief sex therapy may thus offer a 75% immediate success rate in seven weeks for impotence, which seems wonderful in the face of the years when there was no available successful treatment. Yet clinical caution is advised, since impotence is also a symptom which has a notoriously high relapse rate under any stress. Follow-up is critical yet extraordinarily difficult.

Small improvements in the husbands brought high optimism and positive evaluations from all the wives, even from the wives of men we had counted technically as failures since their symptom of impotence had not reversed sufficiently to achieve intercourse. All of those who completed the course of treatment rated improvement in: communication, sexual knowledge and sexual enjoyment from extra-genital as well as from genital contact.

Sexual symptoms are not life-threatening, but they may be severely disruptive or destructive to individual or to marital adjustment. Therefore, some in-depth questioning is indicated when a symptom such as impotence emerges. The following few preliminary questions from the physician to husband or wife could give perspective even on a busy afternoon when time pressure is real. "How long have you/he been impotent? What do you think is the cause? How old are you/is he? Have you/he been ill? What medication are you/is he on? How much do you/does he drink daily? Have you/has he gone recently for a medical check or to a urologist? What do you/does he think is the cause? Are you/is he depressed? Have you/has he lost appetite, weight or sleep? Do you/does he have erections when you/he wakes in the morning? Will you/he come in to see me or a urologist? What have you done about it? What has he done about it? Have you had an affair? Does she/he know? Do you think she's/he's having an affair? How can I best be of help to you?"

When there is time allotted for a longer interview with the wife of an impotent man these categories may emerge on historical exploration.

Unfaithful

This wife has sought at least a sexual and possibly an emotional solution elsewhere in a liaison.

The physician needs to know why she presents now. Is she seeking: permission to continue the affair/relief from guilt/permission to divorce/someone (the doctor) to set limits on her behavior/help for their marriage or something else? Is she worried about a pregnancy or V.D.? Answers can come from a thorough general and sexual history, plus a careful physical. When did the affair occur—before/after the husband's impotence? How is her sexual response with husband/lover? Does husband know? How did he find out? How did he respond? How committed to her is the lover? Is he free? Will he divorce? How easy has it been to keep the affair secret? How much deceipt, shame, guilt, fear of discovery? Have there been multiple lovers? Have there been any complications in the lover's marriage as a result of their affair? Has he left the patient now? Does she feel upset or depressed about this loss? Has her husband had an affair? When? How long? How did she find out/react?

Then her attitude to her marriage must be assessed. Why did she marry her husband? Does she enjoy some aspects of her marriage: comfort/companionship/security/sports/children? What positives keep her in the marriage now? What problems does she see now in her husband/the marriage/the lover/a separation/a divorce? Have there been any trial separations or serious divorce discussions? Has she doubted/regretted her decision to have an affair and does she plan to remain faithful now? Would she agree to marital/sex therapy? Does she think she can continue to keep the secret in this way? Secrets cause anxiety. Is she feeling upset? Do her children/does her mother know of the lover? Would she want them to know? If they know, what have they said? How dependent is she on her husband emotionally, financially and socially?

It would be unusual for an unfaithful wife who has made outside sex her way of adaptation to present to her physician *unless* there was some discomfort: doubt, guilt, anxiety or depression. Does she have any sexual symptoms/dysfunctions/questions?

Faithful

Here the wife's adjustment of several years to her husband's impotence may suddenly be disturbed by some event: a close friend's divorce or affair: "Should I do something too?" or new sexual knowledge, "I just read an article in Woman's World that impotence can be treated today. Can you help us, doctor?" The physician's approach should proceed as described: A thorough personal sex history plus a physical for both. Also necessary is a detailed explicit history regarding the husband's sexual symptom, her own sexual desires/functioning/activity/fantasies/solutions. Has she thought about possible ways to cope? What? Has she blamed herself/talked to family, friend, minister, counsellor? Has she adjusted in other areas: as a parent, social, domestic, job, special skills, a career? How much closeness, affection, mutuality, trust, respect, honesty, is there in the relationship with her husband? Does she feel sexual/attractive? Is there enough intimacy between them for him to respond and cooperate in a brief treatment program to help them complement their present relationship with improved sexual functioning?

As a physician it is unwise to accept at face value the statement "He would never come for treatment." Rather say: "Tell your husband it will be easier to treat you together. Have him keep this appointment with me 4:00 p.m. on the 10th. If he cannot make it have him call me to discuss it or make a better time." *The husband will usually come in.* He needs to be given recognition for coming in since it shows commitment. "I'm so glad you came in and are concerned. How do you see the situation? Do you think there is a problem? What do think it is? How do you feel about your wife's role in the problem? Is it sexual or a communication problem? Are you interested in obtaining help for it? Couples today can receive sex therapy together. Would you consider this possibility?"

From the Loyola study it is clear that many complex factors interact to produce sexual problems in general and impotence in particular. The other half of the coital equation is the wife of the impotent man, who seems unable to win for losing. If she approaches him for sex she has been labelled in the scientific literature as demanding, domineering and castrating. If she does not approach him she is looked upon as infantile, passive, masochistic, non-sexual or maternal. These theoretical generalizations applied poorly to the 151 women we studied.

What literature is available on the wife of the impotent man is slanted in a sophisticated way toward blaming her for his problem.[1,2] Words like domineering, castrating, mother substitute, sexually demanding or agressive all too frequently appear in theorizing the causation of the husband's sexual symptom. It is implied that if he had another partner, seductive, submissive, adoring and less maternal, then he would not be impotent. Using this line of reasoning many men have attempted self-help for their impotence by having sex outside of a coupleship or marriage.

Unfortunately, in the past and even today a doctor may suggest that a man with suspected psychogenic impotence go to a prostitute—using this same stereotyped rationalization: That his wife is the etiology of his impotence, and that a prostitute is a "sexpert," without emotional impact and is, therefore, non-threatening. Sometimes, as our study noted, this extra-marital contact may be reported as helpful. However, for many the impotence persisted with the new partner and there was further (even disasterous) loss of self-esteem to an already sexually insecure man. A newspaper headline reported a note, "I can't even make it with a prostitute," by a 28 year old man who then attempted suicide in a motel room.

Historical Perspective

In the late 1800s, Freud and subsequent psychoanalysts sought causes for impotence within the unconscious of the patient in contrast to prior medical theories which blamed masturbation or the size of the penis.[3,4] Freudians implicated many intrapsychic dynamics: repressed hostility towards women (starting with mother); castration anxiety upon confronting a woman without a pendulous penis; identification with a passive feminine role where a man prefers to be not penetrator but penetratee; fear of damage to the penis by insertion into the unknown dark canal of the vagina (vagina dentata); unconscious anxiety about impregnation and parenting; inability to risk closeness for fear of absorption of the fragile self by another; a deep passivity and masochism. Then there is the favorite old hypothesis often used to explain impotence: the "mother/madonna complex" where husband presumably sees wife as mother.[2] The incest taboo allegedly then interferes because the idealized mother is pure and to him sexually untouchable. These theories kept many men on analysts' couches for long years, discussing the patients' dynamics, yet their impotence remained quite intact and unrelieved. Until Masters-Johnsons' successful new sex therapy, the medical profession had little else to offer.[5,6] Masters' careful studies pointed to sexual ignorance, religious orthodoxy, sexual inhibitions and performance anxiety as high on the list of causes of impotence.[5,7]

The women's movement in the 1960s brought an interesting academic aftermath, namely a spate of articles projecting blame for a "New Impotence" on the increased sexual freedom of women, who were now alledgedly demanding sex for the first time and intimidating their partners to the point of erectile failure.[8,9] However, it is worth mentioning again that psychogenic impotence is perhaps the most ancient sexual dysfunction. It had perplexed and vexed men and their partners for centuries before the term feminist was ever invented.

The difficult burden of the wife of the impotent man has perhaps suffered benign neglect in all the centuries of phallocentric emphasis upon a cure for their partners.[10]

For failures of sex therapy, surgical penile implants are available as another treatment modality for impotence.[11] It was discussed, but only one of 37 men we referred to our Urology Department inquired about its insertion. The penile implant may be of great value to a loving couple, but to a conflictual pair it may simply be one more battle zone.[12]

Every clinician may unfold confusion, self-blame, low self-confidence, rationalization, rejection feelings, resentment, retaliation, resignation, even sometimes relief in the wife of the impotent man. Some of these wives will want to talk, others will not. Some will prefer *not* to be involved in treatment, others will welcome it. At best, optimum health care will encompass the office questions here outlined. At least the physician's recognition of the sexual problem may lead to suggested reading for self-help at home or to referral to a reliable source of help. A better sexual exchange readily improves the quality of life for each partner and eventually assists the adjustment of the entire family. ◀

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Surgical Grand Rounds

John M. Beal, M.D., Contributing Editor

Surgical Grand Rounds are held weekly on Tuesday at 5:00 p.m. in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of January 15, 1980.

Case Report:

PHEOCHROMOCYTOMA

Dr. Jordan Gottlieb: A 56-year-old woman was admitted with a 9 year history of hypertension. Her blood pressure during this period was usually 200/100, although she was taking Dyazide® and Aldomet,® usually in fairly small doses. During an evaluation in 1973, borderline elevation of her urinary VMA was found. In the fall of 1979, she was admitted with ill-defined symptoms, characterized by "strange feelings" starting in her mid abdomen, radiating into her neck, followed by pounding headaches that lasted for one to two minutes, accompanied by a sensation of warmth, sweating and palpitation. She denied any tremors and anxiety and family members did not observe any flushing. She had a recent gain of about eight pounds, and complained of mild polydypsia, urinary frequency, and diarrhea. She said that these attacks could be precipitated by coughing but not by food ingestion, urination, or defecation.

Physical examination: blood pressure 194/100, pulse 88. Her skin was of normal texture and color. There were neither cafe-au-lait spots nor any subcutaneous nodules. Lungs were clear. A grade one systolic murmur was present. No abdominal masses or tenderness were present.

Laboratory findings were significant. Urinary VMA 8.0 (normal less than 6.8), her urinary catecholamines were markedly elevated to 715 (normal less than 180). Urinary 170H and 17 ketosteroids were within normal limits and serum epinephrine was normal. However, serum norepinephrine was markedly elevated, 1404 (upper limits of normal 330). Serum dopamine, parathormone, calcium, and thyrocalcitonin were normal. Radiologic studies included a CT Scan, angiographic and ultrasonic exams, and demonstrated a right adrenal mass. Her preoperative preparation included control of her blood pressure with phenoxybenzamine. She was not given propranol and she neither had tachycardia or any other arrhythmia.

Operation involved exploration of the right adrenal with excision of the pheochromocytoma. The left adrenal and the periaortic nodes were examined from the celiac axis down to the aortic bifurcation and were unremarkable. Her postoperative course was unremarkable, without recurrence of her hypertension.

Dr. Bohdan Wasiljew: It was somewhat unusual that two patients with pheochromocytoma were admitted within two weeks of each other. The second patient to be presented was found to have a pheochromocytoma which involved the organ of Zuckerkandl. This patient was a 40-year-old man who reported juvenile-onset diabetes of 30 years' duration. The patient had severe peripheral vascular disease, and a vascular operation was planned at another hospital. During the induction of anesthesia, the patient's blood pressure increased rapidly to 190/100, associated

TABLE I

Metabolic Products of Pheochromocytoma (Patient #2)

	Pre-Op	Normal	Post-Op
URINARY PRODUCTS	mg/24 hour	mg/24 hour	mg/24 hour
metanephrines	2.4	0.3 - 0.9	0.4
VMA	11.5	0.7 - 6.8	5.3
	7.9		
	8.6		
	μg/24 hour	μg/24 hour	μg/24 hour
catecholamines	405	<180	86
	333		
SERUM			
	pgm/ml	pgm/ml	
norepinephrine	2626	65 - 320	
epinephrine	418	0 - 55	
dopamine	4	0 - 90	
	109		

with angina. The operation was cancelled and the patient was re-evaluated. He did not have a history of hypertension. He reported that in the last several years, control of his diabetes had been more difficult and he had more frequent hypoglycemic reactions. In addition, he had occasional violent behavior reactions witnessed by physicians in the hospital. The patient had more hypertension at the time of coronary angiography and ultimately was treated by coronary artery bypass. Hypertension was again noted and was controlled with nitroprusside drip. The patient was eventually readmitted to the vascular service and underwent a femoral popliteal bypass for limb-threatening ischemia of the lower extremity. Again his blood pressure exceeded 200 systolic and he was treated postoperatively with nitroprusside. At the time of his hypertension in the operating room, 24 hour urine collection for catacholamines was started and was positive.

The patient did not have palpitations, dizziness, or flushing. His past medical history also included two myocardial infarctions. His medications included 20 units of insulin, Digoxin,® Propranolol® and Percodan,® which was used both for his ischemic rest pain and for his rather severe and painful diabetic neuropathy. On physical examination the patient's blood pressure was found to be normal. He had severe diabetic retinopathy and bilateral carotid bruits. The patient also had a cardiac murmur. Abdominal examination revealed no masses and palpation of the abdomen did not provoke any episodes of hypertension, flushing or changes in his behavior. His extremities revealed changes consistent with peripheral arterial occlusive disease. The patient had diminished femoral pulses bilaterally and absent distal pulses.

Routine laboratory examination upon admission revealed no abnormalities. His initial 24 hour urinary VMA, started at the time of his last anesthetic and repeated on two occasions, was abnormal. The results are listed in Table 1. The patient underwent abdominal angiography which revealed a 3x4cm vascular tumor situated just above the origin of the interior mesenteric artery. CT Scan confirmed a perioaortic mass while the adrenal glands appeared to be normal. Other abdominal masses were not detected. Serum catecholamines were measured and abnormal. Both norepinephrine and epinephrine and their metabolites were elevated, which suggested to us that the tumor would have to be either in the adrenals or in the organ of Zuckerkandl. Norepinephrine alone would be produced by a tumor located elsewhere since the converting enzyme is limited to those two locations.

Treatment

The patient was treated with Dybenzyline® and taken to the operating room. At the time of laparotomy, the pheochromocytoma located in the organ of Zuckerkandl was removed without difficulty. His blood pressure was well controlled during the operation and will be discussed by Dr. Koht. His blood pressure did not exceed 150/100 during the operation. His postoperative course was uncomplicated and blood pressure remained normal without medication.

Dr. Gary Dillehay: Selective arteriograms demonstrated normal adrenals in the second case. However, a tumor blush is seen in a mass to the

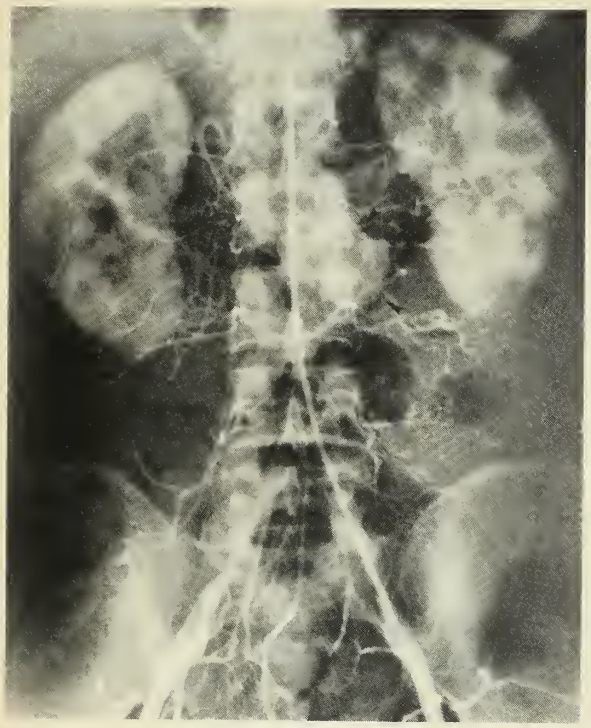


FIGURE 1
Abdominal aortography demonstrated a tumor blush to the left of the aorta, indicated by arrows. (Case 2).

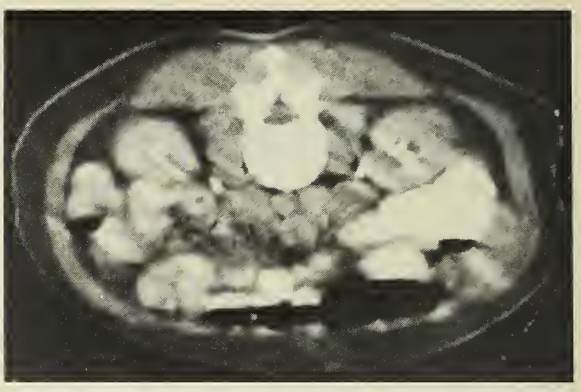


FIGURE 2
CT Scan localized the tumor mass, compatible with pheochromocytoma in the organ of Zuckerkandl.

left of the aorta which is highly vascular (Figure 1). The CT Scan demonstrated that the tumor was anterior to the aorta. (Figure 2) This is compatible with a pheochromocytoma arising in the organ of Zuckerkandl.

Dr. Antoun Koht: Three major problems present during anesthesia for the resection of pheochromocytoma. These are: (1) hypertension before and during the excision of the tumor; (2) arrhythmia and (3) hypotension after the excision of the tumor. Patients with pheochromocytoma have elevated levels of circulating catecholamines which cause increased cardiac contractility, elevated total peripheral resistance and compensatory decrease in circulating blood volume. Intensive monitoring using EKG, arterial line, central line, foley catheter, cardiac output monitoring and calculating the vascular resistance aid in the safe management of these patients.

Hypertension

Both a high level of circulating catecholamines during resting state and their sudden increase during stimulation or manipulation of the tumor can increase cardiac output and the total peripheral resistance, resulting in elevated blood pressure levels. Blood pressure can rise to levels which threaten cardiac function or the integrity of the central vascular system. The proper use of anesthetic drugs which lower the blood pressure (inhalation anesthetics) or have alpha-adrenergic blocking effect (Droperidol®), and avoidance of agents which will increase blood pressure (Ketamine®) increases patient safety. Sodium Nitroprusside,® a rapidly acting, short lived vasodilator, is useful to closely control the blood pressure level. The continuous monitoring of arterial and central venous pressures and the frequent determination of cardiac output assist in using nitroprusside to control peripheral resistance. If total peripheral resistance is low, cardiac output high, and there is tachycardia then an beta-adrenergic blocker is indicated to decrease myocardial contractility.

Arrhythmia

During anesthesia, the combination of high catecholamine levels and increased myocardial wall tension may interact with the decrease in arrhythmia threshold due to some anesthetic agents, to produce a variety of arrhythmia. Halothance® is notorious for this effect and should be avoided. Enflurance® lacks this action of sensitizing the heart to catecholamine arrhythmia and Isoflorane®, when it becomes available, will be an agent which will protect the heart from these arrhythmia.

Supraventricular arrhythmias should be treated if they compromise the circulation. By contrast, ventricular arrhythmia should be treated immediately. Ethrane®, N_2O - O_2 was used in the first patient while high dose Fentanyl®, O_2 was used in the second patient.

In both cases, 2-5 PVC's were noted, but resolved before treatment could be instituted. Si-

TABLE 2

Hemodynamic Changes During Operation for Pheochromocytoma

	Premanipulation	During Manipulation	After Excision of the Tumor
HR	95	117	87
BP	150/70	258/98	163/54
C.O.	6.00	5.34	6.1
SVR	1013	1907	994

nus tachycardia was seen in the second patient during manipulation of the tumor, and Propanolol was used to control this dysrhythmia.

Hypotension following the resection of the tumor

It is well established that hypotension following resection of pheochromocytoma is due to the decreased blood volume. This is induced by the state of vasoconstriction and an associated restriction of circulating volume. This abnormality is best treated preoperatively with alpha-adrenergic blocking agents, such as oral Dibenzalin.® Hydration preoperatively and conscious fluid replacement during surgery will minimize or prevent intraoperative hypotension in a patient properly prepared for surgery. The measurement of right atrial pressure or pulmonary wedge pressure, as a guide for fluid therapy is essential. In the two patients under discussion, Swan-Ganz catheters were inserted and used to monitor the PWP, PAP, C.O., C.V.P. Total fluid (crystalloid, colloid) infused per patient was about 5000ml and this kept PWP between 8-15mm/hg. Hypotension and arrhythmia were not problems in these patients. The only major problem encountered in these two patients was hypertension during exploration of the tumor and this was treated with nitroprusside in both patients. A representative of the hemodynamic is shown in Table 2.

Dr. Bohdan Wasiljew: We do not need another discussion of the treatment of pheochromocytoma. However, I would like to add that there is a new drug which treats the disease a little differently. We talked about blocking the effects of catacholamines, but now there is a drug called Alpha Methol Tyrosine® which prevents the synthesis of catacholamines. We did not use the drug in this case but it may have some use in the future. Certainly, in patients who are not operative candidates or have metastatic disease, this might be a better drug and more physiologic. The following statistics are of interest. The incidence of pheochromocytoma among hypertensive patients (who make up approximately 10% of the population) is somewhere between a half and one percent. This is important because pheochromocytoma is one of the treatable causes of hypertension.

Literature Review

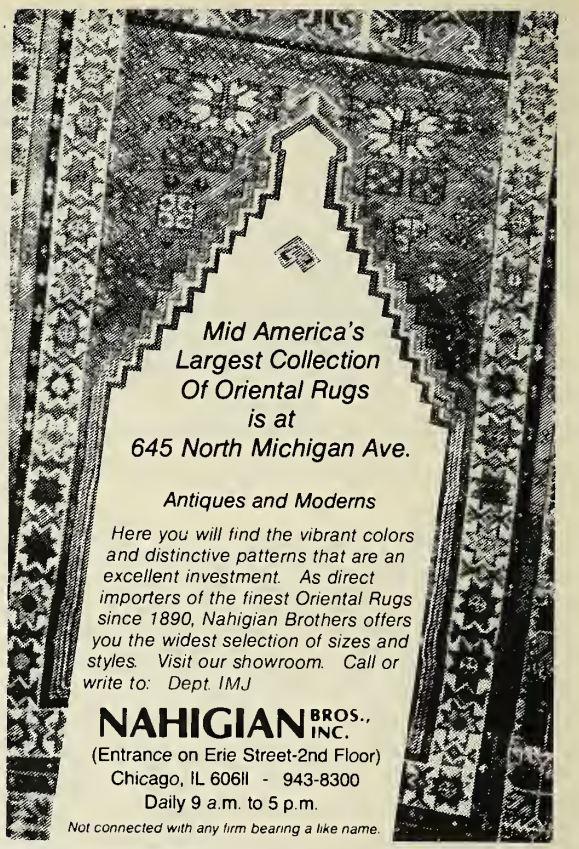
Pheochromocytoma causes approximately 800 deaths annually in the United States and these deaths are almost always in patients with unrecognized tumors, who are operated on for some other disease. Under those circumstances, the mortality is approximately 50%. Pheochromocytomas commonly occur from the 4th through the 6th decade, but also occur in children. There are in fact more multiple, bilateral, extra-adrenal and unusual locations in children. The sex distribution is equal. In terms of physical examination, although approximately 95% of all pheochromocytomas are located in the abdomen, less than 15% can be palpated. However, in some series, 50% of patients experienced attacks of hypertension upon palpation of their abdomen.

In 90%, simple 24 hour urine collections for VMA were diagnostic. In the remaining 10%, other more complicated tests were needed. The cells from the primitive neural fold differentiate into the sympathetic ganglia, the adrenal medulla and the paraganglia. This explains why pheochromocytomas can be found in locations other than the adrenals and why they are almost always related to the main vascular axis of the body. They may be found in the chest, where they are paraspinal, along the aorta in the neck and even higher but they are always behind the mesodermal structure, the pleura or the peritoneum. In one large series which listed almost 200 cases, extra adrenal pheochromocytomas were found in the neck, chest, superior and inferior para-aortic region and around urinary bladder, pelvis, anus and vagina. This series did not list one known case of intracranial pheochromocytoma.

Dr. Stuart Poticha: The patient must have several days of alpha blockades to prepare for

operation. Arteriography should be performed after blockade has been accomplished and just before exploration. Preoperative arteriography is important because 10% of pheochromocytomas are extraadrenal, 10% are bilateral and 10% are malignant. Incidentally, 10% are also associated with medullary carcinoma of the thyroid. Arteriography can be important in localizing the tumor. Despite the many surgical approaches to the adrenal gland, these patients should be explored through an abdominal incision so that the other side and the paraaortic area can be explored. I would like to stress that the symptoms of pheochromocytoma are frequently confused with symptoms associated with more common problems. I have seen two women, one with pheochromocytoma and one with carcinoid syndrome, in whom the flushing attacks were treated with female hormones because they were thought to be hot flashes associated with menopause.

Dr. Julius Conn, Jr.: I think that it is good that we have an extra-adrenal tumor to discuss. Approximately 10% of pheochromocytomas will be extra-adrenal and about 10% will be multiple. Don't find one and close the abdomen without a thorough exploration. ◀



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Seminars in Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

Immunopathology of Insulin Dependent Diabetes

By Bruce S. Rabin, M.D., Ph.D./Pittsburgh

Insulin dependent diabetes, a disease which clinically appears to be a single entity, may actually have different etiologies and pathogeneses. Some of these may involve reactions of the immune system against the islet cells of pancreas. Evidence for an immune pathogenesis to insulin dependent diabetes is presented.

The predisposition to develop an autoimmune disease may be partially determined by genetic factors. For example, it is well known that most autoimmune conditions show a higher occurrence rate in the families of the affected individual and that women are more frequently affected than men. Similarly, in animal models of human disease, such as New Zealand mice, genetic factors clearly determine disease susceptibility. The New Zealand Black (NZB) mouse develops an autoimmune-hemolytic anemia, whereas the offspring of an NZB/NZW mating develop a lupus-like glomerulonephritis. In clinical situations, it does not appear that genetic predispositions follow simple Medelian lines. Genetic factors, if they exist, are probably polygenic.

Both autoimmune and genetic factors may be related to either the etiology or pathogenesis of insulin dependent diabetes in some patients. Among the serologically definable HLA antigens the B8, BW15, CW3, DRW3, and DRW4 antigens are positively associated with insulin dependent diabetes.[1] If there is an association between genetic factors which allow for the production of specific immune responses and immunologically induced endocrine disease it is possible that the genetic factor is either represented by an HLA antigen, or is in genetic disequilibrium with it. Thus, just as in experimental models of autoimmune disease where genetics are a factor, there appear to be genetic factors operative in insulin dependent diabetes.

The inheritance of diabetes mellitus has been intensively studied for many years. Familial aggregation of the disease is well known, yet the genetic factors and modes of inheritance remain unknown. Various investigators have implicated virtually every mode of inheritance, including simple autosomal recessive, simple autosomal dominant with incomplete penetrance, and polygenic inheritance. Environmental factors may interact with genetic factors or may be solely responsible for disease. Twin studies utilizing identical and fraternal twins reveal 45-96% concordance of diabetes or glucose intolerence in monozygotic twins in contrast to 3-37% concordance in dizygotic twins.[2]

A recent study has been done with 24 families containing two or more cases of insulin dependent diabetes.[3] 55% of the diabetic pairs identified were concordant for both HLA haplotypes. One case was found in which there were two diabetic siblings sharing no HLA haplotypes. Eight nondiabetic siblings who were HLA identical with the diabetic sibling did have an abnormal glucose tolerance test.

Approximately 7-10% of families with a child having insulin dependent diabetes (IDD) will

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have a second IDD child. In these families an HLA identical sib appears to have a high risk of developing IDD. However, in families with a single case the role of HLA linked genetic factors is unclear.

Viral Infections

It is most unlikely that genetic factors are of themselves capable of initiating an autoimmune disease. It is likely that either antigenic alteration or some type of alteration in the immune system itself is capable, in the proper genetic setting, of eliciting an autoimmune response. For example, a virus may function in one of two ways to produce antigenic alteration: the virus may have structural similarity with tissue constituents or a tolerance breakdown may be caused by alteration of self antigens. Where antigenic similarities between an infectious agent and self antigens exist, the immune response reacting to the foreign antigen will elicit an antibody response which then cross reacts with the host's own tissue. As an example of this, rheumatic heart disease may be due to cross reacting antibodies elicited by certain strains of beta hemolytic streptococci. The sera of approximately 55% of patients with this disease contain an antibody to beta hemolytic streptococci which reacts with myocardial but not other tissues. If a viral infection occurs in a patient and that virus has an antigen which is cross-reactive with human insulin-producing cells of the pancreas, autoimmune diabetes may occur.

The most commonly implicated viruses are the myxoviruses. The mechanism for viral breakdown of tolerance is not fully known. However, in part, they may be related to the viruses' enzymes, which include neuraminidase, an enzyme capable of splitting sialic acid from proteins and thus exposing new antigenic sites. Alternatively, at some point during the life cycle of the myxovirus, it is present on the cell membrane of an infected cell. This can provide the antigenic stimulus needed to induce activation of T helper cells; the latter in turn can stimulate a response by autoreactive B lymphocytes.

There has been intensive speculation and experimental evidence to support viral infection as a participant in the etiology of IDD. A correlation in the incidence of new cases with mumps infection, where the diabetes follows infections by approximately four years, has been reported.[4] Experimentally, pancreatic islet cell infiltration by mononuclear cells following virus infection has been shown.[5]

There has also been circumstantial evidence for a relationship between prior viral infections and IDD. Gamble measured antibody titers among 123 patients with IDD of recent onset, 155 with diabetes of more than two years' duration and 250 normal persons over a 2½ year period.[6] The sera were tested for neutralizing antibody to Coxsackie virus types B1-B6 and a sample was also tested for complement-fixing antibody to other viral and rickettsial agents. The normal control comprised 177 admissions to a psychiatric ward, 27 orthopedic patients, 18 laboratory staff and 28 others. The age distribution of cases and controls was similar, but not matched. Insulin-dependent diabetic patients within three months of onset were found to have higher antibody titers to coxsackie B viruses, especially B4, than either normal subjects or patients with diabetes of longer duration. No evidence was found for an excess of antibodies to mumps or any of the other common respiratory viruses.

It is impossible to determine from this study whether the coxsackie virus infections occurred before or after the onset of diabetes. Variations in the geographic origin of cases and the time when sera were drawn could also have influenced the results. The controls were not matched for geographic areas and origin or time when samples were obtained. However, partial adjustment for these variables did not exclude the differences in titers for coxsackie viruses between the juvenile onset diabetes of recent onset, IDD of longer duration and the controls.

Cudworth studied 110 people with insulin-dependent diabetes as soon as possible after diagnosis.[7] Each onset occurred before age 30. The genetic and viral interrelationship were evaluated. Twice as many cases were reported during the fall and winter months than spring or summer. The HLA penotyping showed an excess of HLA B8 with a relative risk of 2.58. There was also an increased relative risk associated with HLA types B18 and BW15 (2.32 and 1.9 relative risk). The BW15 HLA type tended to cluster during the winter months. Serum samples were examined for antibody titers to ten viruses. There was significant increase in coxsackie B1 antibody titers in subjects positive for both HLA types B8 and BW15. There was not other evidence of a relationship between a viral antibody titer and HLA type. Antibody titers to coxsackie B1 and B5 also tended to be higher during the winter peak. Finally, there was no relationship between viral antibody titers and presence of islet cell antibody.

Craighead carried out a retrospective study of diabetic children attending summer camps in New England during 1969. The prevalence of serum antibody titers against coxsackie B1 was significantly greater in girls with IDD than in control

children of the same age and sex.[8]

The incidence of IDD is increased among children with congenital rubella. In a long-term follow-up of patients with congenital rubella in Australia, 9/45 followed from birth to age 26 had developed juvenile onset diabetes. None of the cases had first degree relatives with IDD. Experimental congenital rubella infection in rabbits caused histological changes in the beta cells of the pancreatic islets, similar to those found in mice made diabetic by the M variant of encephalomyocarditis.

Epidemiological studies have suggested a viral etiology for IDD. The seasonal distribution with peaks in winter and fall may be related to the seasonal variations in viral infections. There have been reports of simultaneous IDD onset among siblings, suggesting a common etiological agent. The studies of the British Diabetic Association suggest that there may be substantial geographic variations in the incidence of IDD not attributed to differences in case ascertainment. There has, however, been no study that shows a clustering of diabetes within a community nor during a specific time period. Also there is very little evidence for or against temporal variation by year as compared to the seasonal variations within years.

Strong support for a viral induced etiology in some insulin dependent diabetic patients was recently derived from a study of a single patient who died shortly after the onset of diabetic disease. The pancreas was found to be infiltrated with lymphocytes and a virus was isolated from the patient's pancreas. Evidence of recent infection with this virus was obtained by showing a rise in antibody titer to the virus in the patient's serum. When this virus, possibly a coxsackie B4, was inoculated into mice, there were resultant beta cell necrosis, hyperglycemia and inflammatory cells found in the islets of Langerhans. The virus was demonstrated within the beta cells.[9]

Lymphocytic Regulatory Defects

Another means by which autoimmune disease may occur are through alterations occurring in the immune apparatus rather than in the antigenic environment. In normal individuals, the development of self reactive clones of immunologically competent lymphocytes is suppressed. However, if the integrity of the immune system is compromised, such cells may arise and thereby initiate reactions directed at endogenous self antigens. In the present form, this theory represents a modification of Burnett's original postulates regarding "forbidden clones".

Experimental evidence supporting this concept has been derived from New Zealand mice which are prone to develop autoimmune diseases. These animals show a basic defect in their capacity to generate certain immune responses. This defect is present prior to the onset of autoimmunity. It has been suggested that, as one manifestation of this defect, these animals are unable to recognize and suppress the activity of autoreactive lymphocytes. As such, clones of autoreactive cells proliferate and subsequently initiate immune injuries. In contrast, the immune system of normal animals is capable of suppressing generation of self reactive cells. Thus, this theory implicated defective suppressor activity as a fundamental abnormality in autoimmune diseases.

Suppressor activities have been attributed to a population of thymic dependent lymphocytes, and therefore abnormal thymic function may be a primary cause of defective regulatory mechanisms. This activity appears to be separable from the other activities of T lymphocytes, *i.e.*, mediators of cellular immunity, "killer" function and "helper" activity. The role of the suppressor activities of the thymus in autoimmune diseases has been shown to be important in certain strains of mice. Thymectomy in the NZB/W strain accelerates the autoimmune renal disease whereas adoptive transfer of normal T lymphocytes can retard its progression. This suggests that defective T lymphocyte suppressor activities may be an important factor in the expression of autoimmunity.

A recent report on an experimental model of diabetes is relevant to the concept that loss of suppressor lymphocytes may participate as part of the pathogenesis of some types of insulin-dependent diabetes. Mice were infected with encephalomyocarditis (EMC) virus. This infection produces diabetes. However, if the animal is treated with irradiation and then infected with the virus, glucose levels remain normal. This implicates an immune response to the virus as part of the pathogenesis of the diabetes. If the animals were given cyclophosphamide there was an increase in the serum glucose level over that seen in animals only given the virus, and in addition, there was an increase in the intensity of the insulitis produced. Cyclophosphamide is known to decrease the functional activity of suppressor lymphocytes. Thus, loss of suppressor lymphocyte leads to an intensification of the disease in EMC-infected animals.[11]

There is a strain of rat in which insulin dependent diabetes spontaneously develops. If these rats are treated with anti-lymphocyte sera, before the disease develops, there is no development of diabetes. Once the animals have their disease and are treated with anti-lymphocyte antiserum,

TABLE 1

The steps in the development of a relationship between autoantibodies and insulin dependent diabetes include the following:

1. The increased prevalence of juvenile onset diabetes among patients with Addison disease, pernicious anemia and thyroid disorders and the observation that gastric antibodies are common in patients with insulin dependent diabetes, but not in noninsulin-dependent diabetes.
2. The identification of pancreatic islet cell antibodies in insulin dependent diabetes. The antibodies generally are present prior to the clinical onset of diabetes and often disappear after the clinical disease has been present for a time. Approximately 60% of insulin dependent diabetic patients of less than one year duration have islet cell antibodies. The antibodies tend to persist longer in those cases in which there is other aspects of autoimmune disease.
3. A relationship between HLA and islet cell antibody. Studies suggest that B8 and B15 HLA types are more often associated with the presence of islet cell antibodies.

approximately one-third develop normal glucose tolerance tests. Thus, this data indicates a primary role for lymphocytes in this experimental system. Whether the disease is initiated by a viral infection in the pancreas which is stimulating a lymphocyte mediated immune response or due to some type of regulatory defect of the lymphocyte is unknown.[10]

Clinically, it is commonly recognized that individuals with various immune deficiencies are prone to develop autoimmune diseases. Patients with hypogammaglobulinemia (either the congenital sex-linked form or the acquired type) develop an arthritis similar to rheumatoid arthritis. Although the pathophysiological processes in this disorder are not fully known, it may result from either chronic viral infections, disordered cellular immunity and/or deficiencies in T suppressor cells. Evidence has been presented to indicate that deficient T suppressor cell function is of importance in the lupus-like syndromes seen in the NZB mice, and it has been postulated that deficiencies in T cell function are of prime importance in the genesis of autoimmune disease. Thus, there is accumulating evidence suggesting faulty immune regulation as one prime determinant in autoimmunity.

In accord with a theory implicating an alteration in the immune apparatus as being the etiology of autoimmune disease one would expect to find antibody directed to multiple tissue in such patients. We have recently confirmed this in patients with idiopathic oligospermia and in patients with oligospermia secondary to ethanol ingestion. Those patients with idiopathic oligospermia have circulating antibodies directed to the testicle and spermatoza as well as to the adrenals, smooth muscle and mitochondria. Ethanol, which induces an alteration in testicular morphology, leads to the production of antitesticle and sperm antibody. However, chronic alcoholics do not develop antibody to other tissue. Thus, in this idiopathic condition, which may be immunologic in nature, there is evidence for a generalized breakdown in normal immunologic controls. Similar observations have also been reported in patients with insulin dependent diabetes.

Multiple Immunologic Abnormalities

There is substantial information indicating that patients with diabetes have multiple immunologic abnormalities. In one study of 200 insulin-dependent and 200 noninsulin-dependent diabetics, four percent of the insulin-dependent diabetics has pernicious anemia. This was significantly higher than in the noninsulin-dependent groups.[12] Antibody to intrinsic factor and parietal cells was found much more frequently in the insulin-dependent diabetics. Diabetic patients had a higher incidence of antibody to thyroglobulin than normal individuals. This was especially true in patients over 40 years of age. Irvine measured antibody to the thyroid gland and parietal cells in 1,054 diabetics without disease of these organs and in 871 controls. The young insulin-dependent diabetics had an increased incidence of antibody to the tissues studied and the presence of antibody did not correlate with the duration of disease.[13]

Nissley divided insulin-dependent diabetics into two groups, one with antibody to the thyroid, parietal cells or adrenal gland and another group without such antibodies. Looking at the parent and siblings of the patient, a higher frequency of antibody to these tissues was found in the group where the patient had antibody to these tissues.[14]

We have recently examined 290 juvenile diabetics treated at the Joslin Clinic, Boston, MA,

and at the Children's Hospital of Pittsburgh, to determine the prevalence of autoantibodies. Using an indirect immunofluorescent technique, we screened for autoantibodies to the pancreatic islet cells, to parietal cells of the stomach, to the cells of the parathyroid and adrenal glands, and to the testis. Thyroid microsomal and thyroglobulin antibodies were evaluated by hemaagglutination techniques. One hundred and sixty-eight patients have autoantibodies to one or more of these endocrine organs; of these, 64 have autoantibodies to the pancreas. Forty-five of 168 patients with autoantibodies to one or more of these tissues fell in the age range of 12 to 14 years, compared with 24 of 122 patients without autoantibodies.

Lendrum previously evaluated newly diagnosed diabetics for the presence and persistence of autoantibodies to endocrine organs, including pancreatic islet cells. Islet cell antibodies were present in 85% of insulin-dependent diabetics at the time of diagnosis, but decreased to about 50% at one year from the time of diagnosis. Their prevalence was independent of age. The prevalence of thyroid and gastric autoantibodies increased significantly with age.[15]

The age-dependent peak of autoantibodies in insulin-dependent diabetes suggests that the immune system and autoimmunity may be important in the pathogenesis of one type of insulin-dependent diabetes. The age range with maximum autoantibody production coincides with puberty. Puberty is associated with thymic involution and with increased sex hormone production, factors associated with exacerbation of autoimmunity in experimental systems, especially with NZW/NZB mice. This increased occurrence of diabetes at puberty has been previously noted, and we suggest that this phenomenon may be associated with an autoimmune type of insulin dependent diabetes.

The lymphocytic infiltrate found in the pancreas of patients dying soon after the onset of diabetes suggests that a cell mediated immune response may be involved in the pathogenesis (either primary or secondary) of this disease. Using a test to detect the release of soluble mediators from lymphocytes, it has been shown that components of the pancreas are capable of releasing mediators from the lymphocytes of patients with insulin dependent diabetes. Insulin itself has been shown capable of inducing mitosis of lymphocytes of patients with diabetes. Such observations provide evidence that the lymphocytes of diabetic patients are primed to react with antigens of the pancreas but do not implicate such reactivity in the pathogenesis of disease.

Summary

It is obvious that a great deal of complexity is now being introduced into the understanding of insulin dependent diabetes. Viruses and immune response genes are receiving much needed attention. It is possible that the mortality rate between definable subsets of patients with diabetes may differ. It is important to learn the significance of the classification into types of diabetes based on immunologic criteria, and to check the validity of such classification schemes. ◀

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Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

Arthritis/Dermatitis Syndrome—Part III

A 24-year-old female was evaluated for bilateral ankle pain and skin rash. Two weeks earlier she had noted fleeting pains in her elbows and knees, rapidly followed by persistent left ankle pain. Aspirin was instituted with only mild relief. One week later she noted onset of red painful nodules over both tibial surfaces. Concomitantly, right ankle pain began. Admission to the hospital followed.

She denied recent sore throat, upper respiratory tract infection, diarrhea, urethritis, conjunctivitis, lymphadenopathy, rash, vaginal discharge, pleurisy, exposure to or prior history of TB. She denied recent travel. She had no prior history of arthritis. An oral contraceptive was her only medicine. She denied drug allergies. Further review of systems was unrevealing.

On examination, vital signs were normal. Positive findings were limited to the lower extremities where several erythematous, exquisitely tender, nonmovable subcutaneous nodules, 1cm in size, were noted. There was bilateral ankle edema with mild pitting present, and tenderness and warmth of both ankles. Further examination was unrewarding.

Laboratory

Complement blood count, SMA 18, urinalysis and complement levels were normal. Rheumatoid factor and antinuclear antibodies were absent. RPR, ASO and monospot were negative. Chest X-ray was clear and ankle X-rays demonstrated soft tissue swelling. Aspiration of the ankles was unsuccessful. An intermediate strength ppd was negative, but mumps antigen provoked a positive reaction.

Comment

The erythema nodosum syndrome is a nonspecific hypersensitivity reaction to a variety of antigens. This clinical entity is constituted by the acute onset of crops of erythematous painful nonpruritic subcutaneous nodules, usually on the anterior tibial surface, and more rarely, on the buttocks or upper extremities. The lesions are 0.5 to 2.0cm in size, tender, rarely coalescent, and associated with local warmth and edema. Local hemorrhage may occur. When directly over the ankle, such edema may mimic articular swelling. Resolution of lesions often occurs in 3-6 weeks without ulceration or scarring, but recurrence is frequently reported. Often the lesions are associated with nonspecific systemic symptoms such as low grade fever, malaise and loss of appetite. Arthralgias are common and frank arthritis can occur, usually in the lower extremity. Histologically, inflammation of subcutaneous fat with lymphocyte infiltration about septal veins is noted. Such changes must be clinically and histopathologically differentiated from other causes of panniculitis including those associated with pancreatic disease, systemic vasculitis, erythema induratum, or Weber Christian disease.

The syndrome is associated with a variety of underlying diseases (Table 1). Historically, TB accounted for a large percentage of the cases, the lesions arising in primary or recurrent infection. Recently, BCG innoculation has also been shown to produce erythema nodosum. Systemic fungal

Table 1

Associated Disorders of Erythema Nodosum

Microbial	Chronic Inflammatory
Tuberculosis	Ulcerative colitis
Streptococcal infection	Regional Ileitis
Lymphogranuloma venereum	Sarcoidosis
Histoplasmosis	Bechets syndrome
Coccidiodomycosis	
N. American Blastomycosis	
BCG	
Yersinia	
Psittacosis	
Cat Scratch fever	
Leprosy	
Deep trichophyton infections	
Drugs	**Idiopathic**
Bromides	
Iodides	
Sulfonamides	
Oral Contraceptives	
Salicylate	
Phenacitin	

infections such as histoplasmosis, coccidiodomycosis and N. American blastomycosis may also cause the syndrome. Presumably in each of these, disseminated microbial antigen accounts for the immunologic response leading to arthritis and dermatitis. Other microbiological organisms, especially B-streptococcus and lymphogranuloma venereum have been found to cause the symptom complex. Chronic inflammatory states not clearly microbiological in nature, such as the inflammatory bowel diseases (ulcerative colitis and regional ileitis) or sarcoidosis, may have onset or exacerbations heralded by erythema nodosum. In sarcoid, the triad of erythema nodosum, arthritis and hilar adenopathy (Lofgren's syndrome) is said to portend a good prognosis. Many drugs have also been associated with the syndrome. Prominent among these are oral contraceptives and sulfonamides.

Evaluation of any patient with erythema nodosum should be geared toward discovery and elimination of associated conditions. Therapy remains nonspecific. Both the arthritis and dermatitis abate rapidly after resolution of the underlying disease or removal of the offending drug. Nonsteroidal anti-inflammatory agents such as indomethacin can be given for joint complaints, as can intra-articular injections of cortisone for more persistant cases. Often, the syndrome is self-limited, and no therapy is needed. Chronic systemic steroids should be avoided unless needed for the underlying disease.

Conclusion

A diagnosis of erythema nodosum as the cause of subcutaneous nodules and arthritis in this young adult female was confirmed by skin biopsy of a lesion. In view of her non-diagnostic history, laboratory and physical examinations, oral contraceptives were considered to be the most likely offending agent. These were stopped and indomethacin, 25mg QID was begun, with good initial relief of joint pains. Skin lesions and arthritis were gone at 4 weeks and alternate contraceptive methods were suggested. At a six month followup, she demonstrated no recurrence of the disease.

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Further bibliography available from the authors upon request.

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Viewbox

(Continued from page 6)

Diagnosis: Perforated colon carcinoma—familial polyposis coli

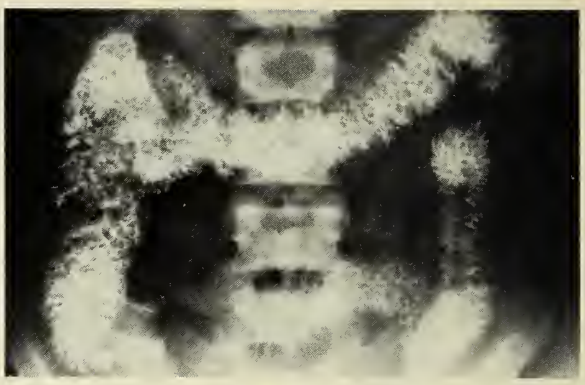


Figure 3
Another patient with familial polyposis. The entire colon is carpeted with myriads of small adenomatous polyps.

All of the choices given can result in extravasation of contrast material from the colon. This patient, in addition to extravasation, has numerous filling defects representing colonic polyps (Figures 1, 2). He has familial polyposis which accounts for the development of colon carcinoma at such a young age. He was treated with total colectomy and is alive five years later.

An intestinal polyposis syndrome should be considered if a polyp is identified in a young patient, colon carcinoma is present in a patient under age 40, several polyps are found in a patient, or cutaneous findings known to occur in polyposis syndromes are discovered.[1]

Gastrointestinal polyposis syndromes include:
(1) Familial polyposis
(2) Peutz-Jehgers syndrome
(3) Gardner syndrome

Rarer syndromes include:
(1) Cronkhite-Canada syndrome
(2) Juvenile polyposis
(3) Multiple Hamartoma syndrome
(4) Blue rubber bleb nevus syndrome
(6) Turcot syndrome

Familial polyposis is characterized by numerous adenomatous polyps of the colon, but at least 5% of patients have gastric, duodenal or small bowel polyps.[2] This hereditary disease is the most common gastrointestinal polyposis syndrome and occurs about 1:8000 births. It is transmitted as an autosomal dominant. One-third of patients have no family history and are considered to be mutations. Unlike the other polyposis syndromes there are no findings outside the gastrointestinal tract.

The polyps in this syndrome are adenomatous and usually appear after puberty, but appearance before age 10 (? homozygous) and after age 40 have been reported. The polyps range from 1-2mm to over 1cm in diameter and may be sessile or pendunculated. The left colon is more frequently involved but polyps are often present throughout the colon. The colon may be carpeted with countless polyps (Figure 3). Polyps are almost always present in the rectum. Tiny 1-2mm polyps may not be identifiable unless air-contrast barium enema technique is used. Filling defects due to polyps on barium enema may simulate fecal material. Doubts can be resolved with a repeat study or endoscopy. A large number of diseases cause multiple polypoid colon lesions and some of the other polyposis syndromes are characterized by non-adenomatous polyps with low malignant potential. Biopsies are needed to characterize the polyps in each patient.

Patients with familial polyposis become symptomatic at age 20-40. The most common symptoms are diarrhea and blood in the stool. Patients may also have abdominal pain, weight loss and, rarely, symptoms related to electrolyte or protein loss. Adenocarcinoma develops about 15 years after the appearance of polyps and virtually all untreated patients will develop carcinoma by age 50.

Treatment consists of total colectomy. The reported incidence of cancer developing in the rectum following iliorectal anastomosis varies widely. Patients with retained rectal mucosa require twice yearly proctoscopy for life. Family members at risk should be screened and followed with periodic examinations.[3]

Gardner syndrome is an inherited (autosomal dominant) polyposis disorder in which adenomatous colonic polyps develop in childhood or early adult life. Less than 5% of patients have gastric or small bowel polyps. Polyps are fewer in number and more scattered than in familial polyposis but the potential for malignancy is the same. Virtually all untreated patients will develop colon carcinoma. Extracolonic features of Gardner syndrome include multiple soft tissue mesenchymal tumors, skeletal osteomas, dental abnormalities, retroperitoneal and mesenteric desmoid tumors and fibrosis, and a tendency to form hypertrophic scars or keloids. There is an increased incidence of pancreatic and periampullary carcinoma.[1] Some investigators think that familial polyposis and Gardner syndrome are differing manifestations of one disease.

Peutz-Jehgers syndrome is a hereditary disorder (autosomal dominant) but one-half the patients are sporadic cases with no family history. A majority of patients have small bowel polyps, about one-third have colon polyps and one-fourth have gastric polyps. The gastric and small bowel polyps are hamartomas which do not become malignant. The colon polyps are adenomatous polyps. The incidence of gastric, duodenal and colonic carcinoma is increased in Peutz-Jehgers syndrome. Up to 1972, carcinomas at these sites had been reported in 15 patients.[4]

Symptoms are related to small bowel polyps and include abdominal cramps related to intussusception (often recurrent), rectal bleeding, and anemia. Mucocutaneous pigmented macules are present in almost all patients. They usually develop during early childhood. The most common sites of these brown to black lesions are the lips and buccal mucosa. The face, palms and soles are less frequent sites of pigmentation.

Cronkhite-Canada syndrome is a rare non-hereditary polyposis syndrome which has been reported in children but usually occurs after age 40. All patients have gastric and colonic polyps and a majority have small bowel polyps. The polyps are the juvenile type with no malignant potential. Prominent extra-intestinal findings include atrophy of the nails, loss of body and scalp hair and hyperpigmentation of the upper extremities. Symptoms include diarrhea, anorexia, weight loss, abdominal pain and vomiting. Electrolyte and protein loss are often severe. The prognosis is grim, especially in women, but spontaneous remissions have occurred.[1]

Juvenile polyposis is a rare, usually non-hereditary, gastrointestinal polyposis syndrome. The adjective, juvenile, refers to the histology of the polyps found in the syndrome and not to the age of patients affected. Infants, young children, teenagers, or adults may have juvenile polyposis. Polyps are numerous and most frequent in the colon but they can be found in the stomach and small bowel. These polyps do not become malignant. Patients with juvenile polyposis have the same type of polyps as the Cronkhite-Canada syndrome but do not have the extra-intestinal stigmata of that disease. Some infants with juvenile polyposis have had associated anomalies and early death.[5]

The *Multiple Hamartoma syndrome* (Cowden disease) is a rare hereditary disorder with hamartomas found in tissue from all germ cell layers. These patients have polyps from the esophagus to the rectum. Polyp histology may be juvenile, hyperplastic or adenomatous. Extra-intestinal findings are numerous and include thyroid and breast carcinoma, skin tumors and skeletal abnormalities. Papillomatous gingival hypertrophy is a characteristic finding.[6]

Blue rubber bleb nevus syndrome is a rare, usually non-hereditary, angiodysplagia. The name refers to blue rubber nipple-like skin nodules or blue nevus-like skin lesions. These lesions are cavernous hemangiomas. They are usually present at birth. Hemangiomas may be found in other viscera. Hemangiomas occur in the small bowel, colon, and stomach where they appear as polyps. The most serious problem in these patients is gastrointestinal bleeding.[7]

Turcot syndrome is a rare hereditary (autosomal recessive) polyposis syndrome in which multiple adenomatous colon polyps are associated with central nervous system tumors. Adenocarcinoma of the colon has been reported in these patients. ◀

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Student Business Section in Action

Overregulation By The Feds?

This is the second of a five-part series on cigarette advertising

Recent years have witnessed a growing outcry among businessmen and others over what many perceive to be excessive regulation by the federal government. One item, though, has consistently escaped these shackles: tobacco. Not only has Congress, for example, specifically exempted tobacco from the jurisdiction of the Consumer Product Safety Commission and the Food and Drug Administration, but it has also thwarted almost every attempt by the Federal Trade Commission (FTC) to regulate cigarette advertising.

The Federal Trade Commission Act of 1914, amended in 1938, empowers the FTC "to prevent persons, partnerships, or corporations . . . from using unfair methods of competition in commerce and unfair or deceptive acts or practices in commerce." The FTC, like similar administrative agencies, uses two principle methods to exercise its power: adjudicatory and rule-making authority. Adjudicatory authority, often referred to as quasi-judicial in nature, allows the FTC to move against specific cases of deception and, in lieu of voluntary industry compliance, to issue cease and desist orders. Rule-making authority ("quasi-legislative"), on the other hand, permits an agency to issue general industrywide guidelines (trade regulation rules) as to what may or may not be illegal.

Until 1962, the FTC used only adjudicatory authority. With respect to cigarette advertising, it invoked these powers 25 times between 1938 and 1968. For instance, according to Susan Wagner, author of THE FEDERAL TRADE COMMISSION:

> *A 1942 complaint against Brown & Williamson Tobacco Company prohibited claims that Kools would keep the head clear in winter and give extra protection against or cure colds. . . . A 1945 complaint lodged against R. L. Swain Tobacco prohibited representations that respondent's cigarettes were endorsed or approved by the medical profession; that they would soothe the nose, throat, or mouth; that they contained no irritating properties; and that they produced little or no stain on fingers and teeth. In 1950, the FTC moved successfully to curb R. J. Reynolds Tobacco Company from claiming that Camels aided digestion; did not impair the wind or physical condition of athletes; would never harm or irritate the throat or leave an aftertaste; were soothing, restful, and comforting to the nerves, and contained less nicotine than any of the four other largest selling brands.*

The Commission eventually came to the conclusion that dealing with an industry-wide problem such as cigarette advertising on a case-by-case basis was not very effective. Since the judgment or order in each case applies only to the parties to the case, others engaged in the same or similar deceptive acts are not immediately affected. To move separately against them would delay the process by months or even years. As A. Lee Fritschler observed in SMOKING AND POLITICS, "the Commission found itself putting out brush fires of deception while the inferno raged on."

As a result, the FTC developed procedures in 1962 for exercising rule-making authority. And exactly one week after the Surgeon General concluded in 1964 that "cigarette smoking is a health hazard of sufficient importance in the United States to warrant remedial action," the FTC announced its own brand of remedial action. The Commission proposed a trade regulation rule which would have: (1) required a health warning on cigarette packages and in advertisements such as "Caution: cigarette smoking is dangerous to health. It may cause death from cancer and other diseases;" (2) prohibited the disclosure of tar and nicotine content in ads until the Commission established a uniform testing procedure; and (3) banned "words, pictures, symbols, sounds, devices or demonstrations, or any combination thereof that would lead the public to believe cigarette smoking promotes good health or physical well-being." The latter provision was the most far-reaching proposal ever made by a regulatory agency with respect to cigarette advertising.

Congress, however, had different ideas. Before the trade regulation rule was to take effect, Congress preempted it by passing the Cigarette Label-

ing and Advertising Act of 1965. Although requiring a health warning on cigarette packages, ("Caution: cigarette smoking *may* be hazardous to your health") the law prohibited for three years any requirements by any federal, state, or local authority (including the FTC and the Federal Communications Commission) that cigarette advertisements include a statement related to smoking and health. The NEW YORK TIMES called the new law "a shocking piece of special-interest legislation . . . (a) . . . bill to protect the economic health of the tobacco industry by freeing it of proper regulation," and editorialized that "the President and Congress (are) flashing a green signal to the lobbyists that any regulatory agency is open to invasion and emasculation."

The AMA did not testify in Congress on this matter. F. J. L. Blasingame, a spokesman for the AMA, did however say in FTC hearings that:

> *". . . the health hazards of excessive smoking have been well publicized for more than ten years and are common knowledge. . . . We do not believe that the answer to the cigarette problem lies in cautionary labeling requirements. Experience in other countries indicates that the effect of such labeling at best is only to reduce temporarily the consumption of cigarettes. After a while the habitual smoker ignores the cautions expressed on the label."*

Also, according to Fritschler, the AMA "took the position publicly that Congress, not the FTC, should regulate the cigarette industry, if there had to be any regulation at all." By 1980, nevertheless, the AMA did see fit to recommend that the FTC "seek to eliminate the use of role models in all advertising; require warning labels to be displayed everywhere—packages, advertisements, and billboards; and prohibit any promotion aimed at the age group younger than 19 years" (*JAMA* 243:781).

In 1969, at about the time of expiration of the 1965 Act and its moratorium on agency action, both the FTC and FCC announced proposed rule-making. The FCC trade regulation rule would have banned cigarette advertising from radio and television in the absence of "a contrary congressional direction." The FTC rule would have required a health warning in cigarette ads. Congress again preempted these proposals with the Public Health Cigarette Smoking Act of 1969. It strengthened the health warning on cigarette packages, ("Warning: the Surgeon General has determined that cigarette smoking *is* dangerous to your health") banned cigarette ads on radio and television, but again slapped the FTC with a 15-month prohibition against requiring a health warning in advertisements. Furthermore, any intention of doing so afterwards would have to include a six-month advance notice to Congress. Incidentally, the tobacco industry was not overly dismayed by the television and radio ban, since this would cause the removal of the highly effective anti-smoking public service announcements which were required under the FCC Fairness Doctrine.

The FTC's third proposed trade rule in August, 1970, called for mandatory disclosure of tar and nicotine ratings. This time the tobacco industry was willing to compromise in order to avoid litigation or further Congressional action, and additional negative publicity. Every major U.S. cigarette company except American Brands, Inc. agreed to voluntarily disclose tar and nicotine content in cigarette advertising.

In spite of these few successes, cigarette ads today still use what the FTC proposed to prohibit 16 years ago: "words, pictures, (and) symbols . . . that would lead the public to believe cigarette smoking promotes good health or physical well-being." In fact, the FTC's 1978 Annual Report to Congress states that "some ads use language which directly contradicts the required health warning and scientific evidence that smoking is dangerous to health." With the recent further erosion of the powers of the FTC, including restrictions on its rule-making authority, (Federal Trade Commission Improvements Act of 1980) the prospects for progress in eliminating the deception in cigarette advertising are bleak.

Congress still seems inclined to acquiesce to the tobacco lobby. Until medical associations and other interested parties can convince Congress that 346,000 premature deaths each year are more important than political expediency, tobacco will remain one of the most unregulated products marketed in this country. ◀

Ronald M. Davis
Delegate, ISMS-SBS

This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Student Business Section.

Pulse of the ISMS Auxiliary

Illinois Auxilians Are SASII

BY MRS. HARLAN FAILOR, ISMSA PRESIDENT

Sassy? No! Impudent and insolent we are not—well, hardly ever. Sasii? Yes! As often as possible—you can tell it by the buttons we wear. SASII Auxilians are SPONSORING A SPOUSE IN ILLINOIS. Not just any spouse, but the wife (or husband) of a medical student or resident physician. Mrs. Don Hinderliter, ISMSA First Vice-President and Membership Chairman, introduced this new membership project at Fall Conference in Decatur last October.

The spouse of a physician in training is often working full or part time and, consequently, has few hours for volunteer activity. Yet, at this stage in her life, the fringe benefits of Auxiliary membership would be especially valuable: practical and informative publications put out by State and National *(Pulse, Facets, Horizons),* leadership seminars and conferences designed specifically for the doctor's wife, opportunities to discuss plans and concerns with those who have survived the training years.

Now these advantages can be given to student and resident spouses by members of the State Medical Auxiliary *and* Society via SASII. The steps to "sponsoring a spouse" are: (1) Pay the $5.00 sponsorship fee (AMAA dues of $3.00 plus ISMSA dues of $2.00) to the ISMSA Membership Chairman; (2) Receive the name and address of your assigned student spouse, accompanied by a letter of introduction (which is to be copied in your own handwriting) and a SASII button and (3) Correspond with your spouse informing her of local activities and programs.

The premise upon which this program is based is that familiarity will breed respect, followed by participation. The Auxiliary saw this happen when we invited Nadine Messina, the wife of a Chicago medical student, to attend the AMA Auxiliary Convention last July. She later shared these observations with the ISMSA Delegates:

My husband is a doctor. His profession is a requirement for my membership in the auxiliary. Is that right? I'm supposed to be independent and liberated. What would my feminist friends think?



Mrs. Don Hinderliter (L), ISMSA First Vice President in charge of Membership, pins a SASII button on ISMSA President Mrs. Harlan Failor.

I glanced at the Delegates' Handbook. This organization has sponsored a Convention with a House of Delegates and Reference Committees. What can these women find that is so important to channel it through formal procedures?

As I entered the House of Delegates, I immediately knew that the auxiliary does not sponsor tea and crumpet parties. It is a group of people, not all women, sincerely dedicated to improving the health of the American people. I began to realize that I was surrounded by lawyers, accountants, managers, secretaries, nurses, teachers, and others who happened to be married to doctors and who were deeply concerned about health and the practice of medicine.

Improving the health of the people in your family, your community, your country is a cause every person should be part of. I realized that being an auxiliary member was not a step away from liberation, but a step toward helping to improve the quality of life for a lot of people."

In a memorandum to County Membership Chairmen, Mrs. Hinderliter points out that many organizations will be after these physicians' spouses once they have settled into a community. "I am hoping the personal contact they receive from us at this point in time will be remembered. I hope every one of you will get behind SASII and get to know these young people through your correspondence with them. They are energetic, enthusiastic, and, most important of all, they are the future of our organization."

Let's *all* get SASII ◀

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Chicago, IL 60610

Please send me information and registration materials for the 1981 Midwest Clinical Conference:

Name _____

Address _____

Zip Code

President's Page



An Idea For The 80's:

Media Know How

Success in communicating is knowing the territory.

The stage belongs to the anchorman in TV news, and the audience varies. In the daytime, it may be housewives . . . in the evening it is the family . . . and adults comprise the majority of late night viewers. An interview covering 10-minutes or more may be cut to several sentences when it is aired. The "big story" may occupy the screen for only two minutes. Considering these factors, a well-prepared mini-speech (approximately 30 seconds) appears to be the most effective method of making your point.

TV discussion programs and interviews with print media reporters present different problems. The subject should be agreed to in advance and limited in scope. Prepare by developing several succinct points you want the audience to remember. Anticipate questions and tailor your responses to emphasize the main points you identified earlier.

Medicine regularly is in the news, and reports frequently are slanted to place the profession in a bad light. Effective spokesmen can counter this tendency. The techniques needed to make an effective presentation can be learned. The AMA has an excellent program which teaches these techniques. Investing time in this educational process should be a high priority of county medical society leaders. ◀

Herschel Browns, M.D., President

Doctor's News

PHYSICIANS IN THE NEWS—Seymour Diamond, M.D., Chicago, has been elected Executive Officer of the Migraine and Headache Research Group, World Federation of Neurology **John M. Beal, M.D.,** Chicago, was elected vice president of the Council of Medical Specialty Societies (CCMS) at their recent annual meeting. The CCMS is composed of 24 specialty organizations representing diplomates of either a primary or conjoint examining Board recognized by the American Board of Medical Specialties. Dr. Beal, who represents the American College of Surgeons for CCMS, is editor of the *IMJ* "Surgical Grand Rounds," column.

ESTABLISHING YOURSELF IN MEDICAL PRACTICE—ISMS will sponsor a two day workshop in practice management for new physicians on January 27-28 and January 29-30, 1981, at the Society's offices in Chicago. Presented by Conomikes Associates, the workshop is intended to introduce physicians to techniques for organizing medical records, financial management, economic and legal aspects of private practice, and practice building techniques. Cost of attendance is $95 for ISMS members and $125 for non-members. Further information may be obtained through the ISMS offices, (312) 782-1654. Attendance will be limited and early enrollment is recommended.

ISMS TRAVEL PROGRAM—Positions are available for persons wishing to join the *Rhine/Alpine Adventure,* departing June 30 from Chicago and St. Louis and returning July 12, 1981. Also available is the *British Isles Adventure,* touring Ireland, Scotland and England. That trip departs Chicago and St. Louis July 16 and returns July 27. Further information is available from the ISMS offices, 55 E. Monroe, Suite 3510, Chicago IL 60603.

AMA PROGRAMS ANNOUNCED—The AMA Educational Seminars on Negotiations are scheduled for March 19, Cincinnati, Ohio; May 21, New York City; Septmeber 10, San Diego, California and October 23, Philadelphia, Pennsylvania. Formally titled "Seminars on Development of Negotiating Knowledge and Skills in Intraprofessional and Interprofessional Relationships," the two-day programs are topical. Cincinnati and San Diego programs will provide an introductory program in the dynamics of conflict resolution; the New York program is an advanced seminar on that topic. The Philadelphia program is the Fourth Invitational Conference for Physician Negotiators. For more information, write the AMA Department of Negotiations, 535 N. Dearborn, Chicago IL 60610.

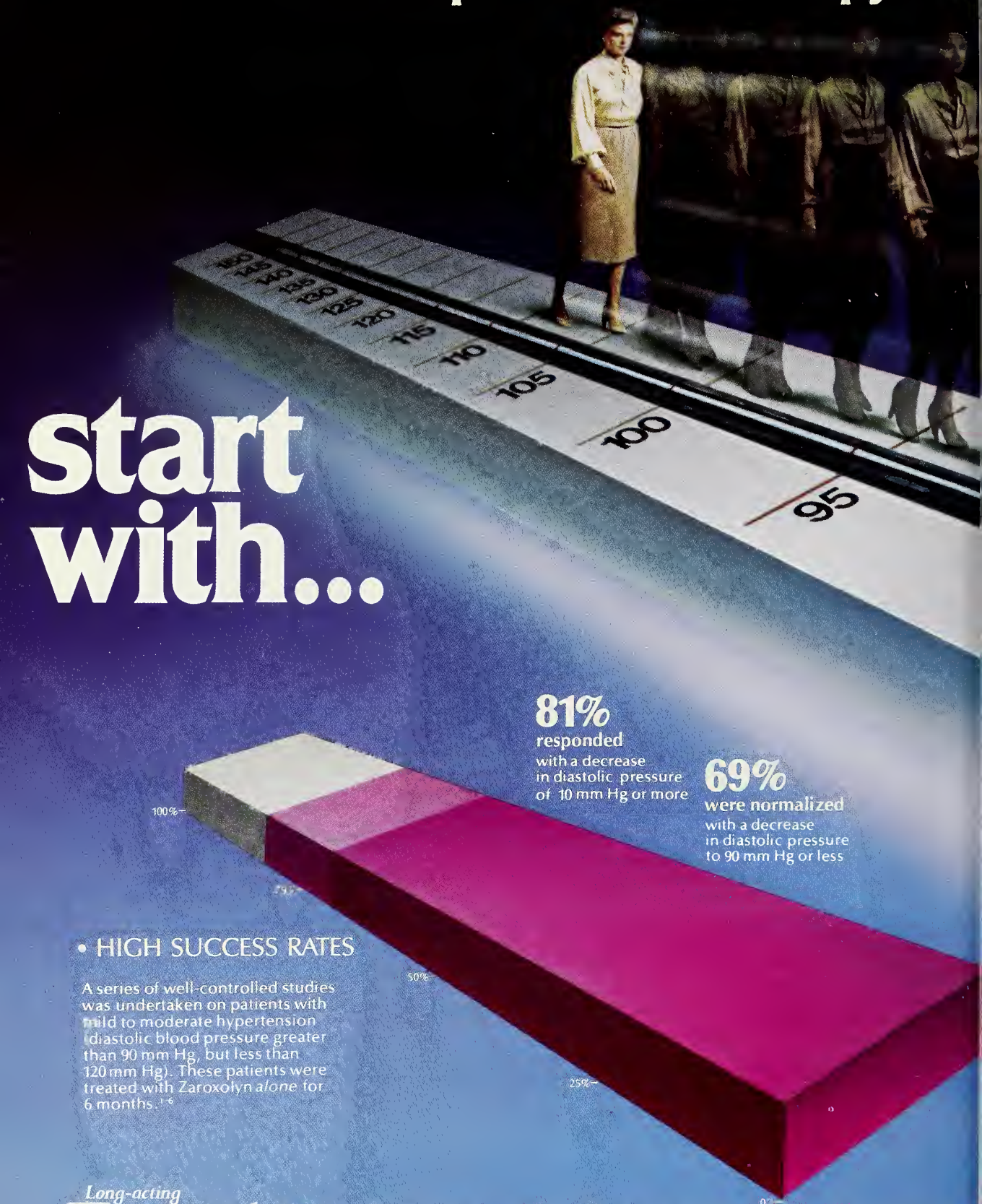
The AMA will also sponsor clinical update meetings at the Chicago Hyatt Hotel on April 3-5, 1981. These seminars, which consist of video clinics and academic faculty, address current topics in the major specialties. It might be noted that the ISMS Annual Meeting will be held April 5-9, immediately following the seminar dates. Further information may be obtained through the AMA Department of Meeting Services, 535 N. Dearborn St., Chicago IL 60610.

JCAH SEEKS PHYSICIAN SURVEYORS—The Joint Commission on Accreditation for Hospitals is seeking physicians to serve as hospital surveyors. Further information may be obtained by writing Janet L. Heckman, JCAH, 875 N. Michigan, Chicago IL 60611.

BROCHURES AVAILABLE—The Illinois State Council on Nutrition has developed a number of patient education brochures, which are available in quantity for physician offices. Information may be obtained through the Council at 524 S. Second St., Suite 405, Springfield IL 62706; (217) 785-8664.

INTRAVENOUS THERAPY CONFERENCE ANNOUNCED—The National Intravenous Therapy Association, an organization for nurses, will hold their ninth annual meeting March 22-26 at the Sheraton Hotel, Boston, Massachusetts. Further information may be obtained by writing them at 93 Concord Ave., Suite 4, Belmont, MA 02178.

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REPORT FOR *Illinois Physicians*

ILLINOIS DEPARTMENT OF INSURANCE APPROVES PREMIUM INCREASE FOR BLUE CROSS AND BLUE SHIELD OVER 65 PROGRAM

The Illinois Department of Insurance early in January approved most of the increase the Chicago-based Blue Cross and Blue Shield Plan had requested for its Medicare supplemental benefit program.

"This increase, the first in nearly four years, will enable us to pay the 13 percent increase in the Medicare deductible and copayments for inpatient hospital care which went into effect January 1," Theodore E. Desch, Plan senior vice president, said.

"The $2.28 increase in the monthly Blue Cross 65 and Blue Shield 65 premium is 20 cents less than our Plan had requested," Desch said. "Although this is a disappointment to us, we have decided not to seek further administrative or judicial review of the decision.

"By accepting the smaller increase and retroactively increasing the benefits to the January 1, 1981, deductible and coinsurance levels, we avoid the imposition of a financial burden on our Medicare supplemental subscribers, which would have occurred if the benefits had been frozen at 1980 levels."

Desch expalined that the Medicare supplemental coverage increase, from $9.60 to $11.88, will be going into effect sometime in the middle of February, because it will take that long to get the billing operation changed over.

"During the past four years," Desch said, "the federal governement has raised the Medicare Part A deductible from $124 in 1977 to the current $204, with corresponding increases in the Medicare copayments.

"While we have not been permitted to increase the premium for Medicare supplemental coverage since 1977, subscribers who have that coverage have received a 79 percent increase in benefits by virtue of our volantarily increasing benefit payments each year," Desch explained. "By contrast, the premium increase just approved amounts to 24 percent over the same four-year period.

"Because the increase approved by the Department of Insurance fell short of the amount we had requested, our actuaries project that our Medicare supplemental subscribers will continue to receive approximately $1.10 in benefits for every $1.00 paid in premiums" Desch said.

FEP BENEFITS UPGRADED

Negotiations with the U.S. Office of Personnel Management regarding the 1980 Federal Employee Program (FEP) contract have been completed.

Because our Blue Cross and Blue Shield Plan covers more than 70,000 Federal Employees and their families in Illinois, we thought you would be interested in some of the changes made in the program. Following are some of the more important changes:

High Option Supplemental Deductible

The High Option deductible for Supplemental Benefits has been increased from $100 to $150. The Low Option deductible will remain at $200.

Mental Illness — Supplemental Coinsurance

The Supplemental coinsurance for *all* services related to the treatment of mental illness will be 30 percent under High Option and 40 percent under Low Option. Charges for the treatment of mental illness, subject to the new $150 (High Option) and the $200 (Low Option) deductibles, will continue to be limited under both options to $50,000 per person per lifetime.

Inpatient Alcoholism Treatment — New Benefit

Under both options, Basic Hospital Benefits will be provided for inpatient alcoholism care for up to 28 days per alcoholism treatment session. Benefits will be paid in full in a member hospital or in a free-standing alcoholism facility which has been approved by the local Plan. In nonmember hospitals, the Plan will pay 80 percent.

Under Supplemental Benefits, the Plan will pay 70 percent (High Option) and 60 percent (Low Option) after the deductible has been satisfied for up to 28 days per inpatient treatment session in nonmember hospitals which are primarily for the treatment of mental illness.

There will be a lifetime maximum of two sessions per person which includes sessions covered under Basic or Supplemental Benefits. Supplemental expenses for alcoholism rehabilitation will be applied to the $50,000 maximum for the treatment of mental illness.

Home Health Care

Home Health Care Benefits will be provided for the 90 days following a covered hospital confinement under High Option and 30 days under Low Option when the home health care begins within three days from discharge from the hospital following a covered admission. Presently, care must begin within 36 hours of discharge. Also, there will no longer be the requirement that medical evidence substantiate that the subscriber would have required further inpatient care had the home health care not been available.

Private Duty Nursing

Supplemental Benefits will be provided for home nursing care for up to two hours per day by a registered nurse or licensed practical nurse when the care is ordered by the attending physician. Up to 90 days of care will be covered under High Option, and 30 days per year under Low Option. Additionally the care will no longer require the technical proficiency and scientific skills of an R.N.

Hemophilia Home Care — New Benefit

Basic Hospital Benefits will be provided for supplies necessary for the home care of hemophilia. Such supplies are currently covered only under Supplemental Benefits.

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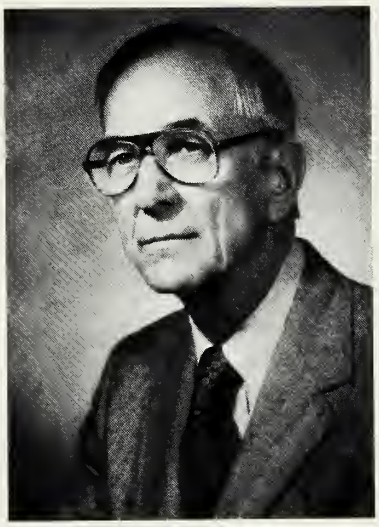
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President's Page



An Idea for the 80's

Access vs. Cost

The 1960s were characterized by rapid expansion of the health care system. The boom encompassed facilities and financing as well as personnel. Dollars were viewed as the solution to all problems, and massive amounts were poured into the system. This approach created a new problem. By the 1970s, red had become the dominant ink color in health care financing.

In the planner's mind, new problems are solved by new programs. In this case, HSAs, PSROs and HMOs. Not surprisingly they were not the solution.

The search continues into the 1980s. The major challenge facing medicine is to maintain patient access to the health care system and operate within the budget. What does the next layer of "solutions" hold? Rumors center on budget cuts or ceilings, deregulation, fee schedules and schemes to increase competition.

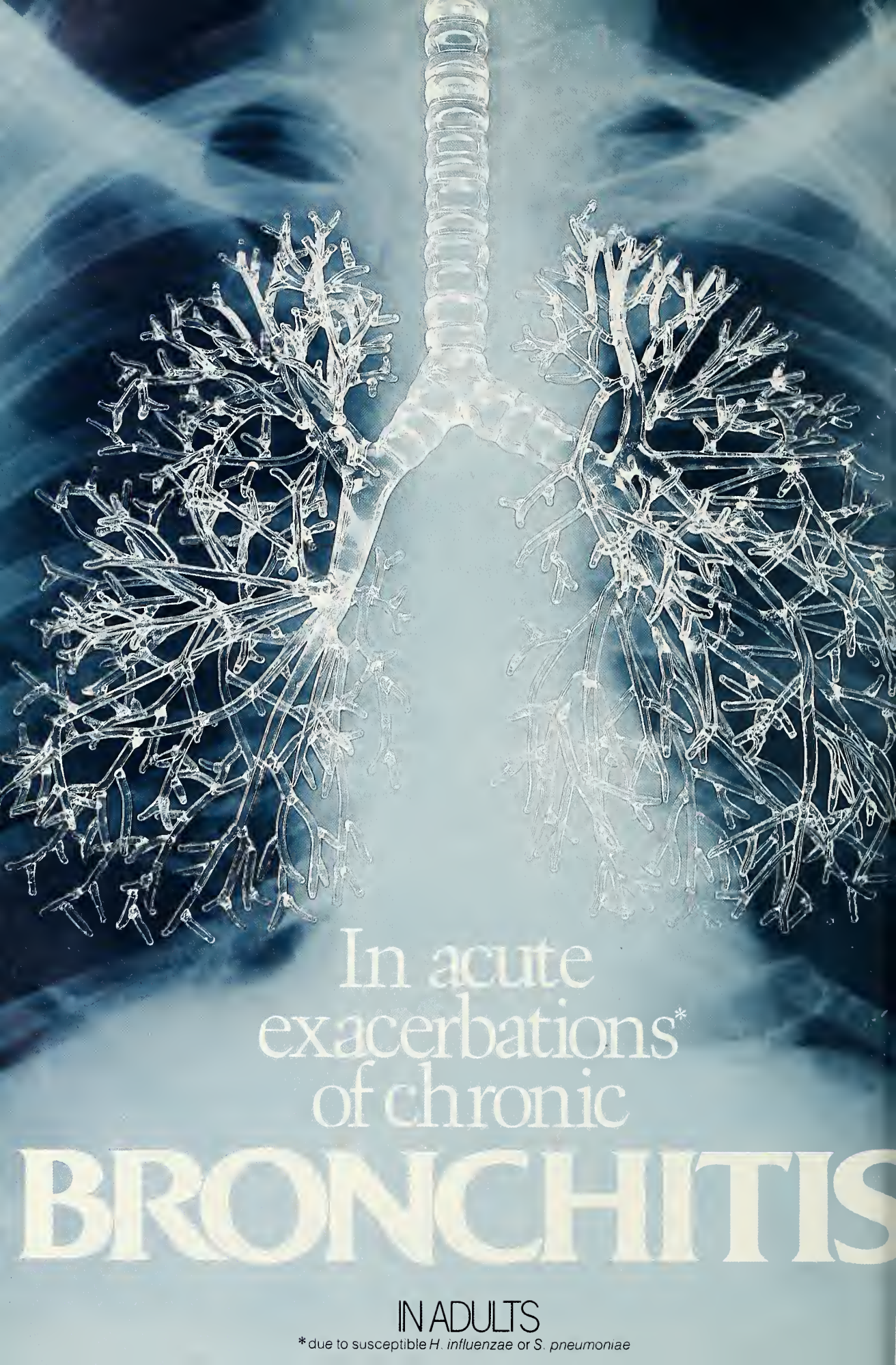
As physicians, we have an obligation to be cost conscious. That duty will take on added significance if the demands of energy and defense become more of a national priority and consume dollars previously available for health care.

Undeniably, physicians—as gatekeepers of the health delivery system—control a large portion of expenditures. An effective way to avoid rationing is to increase the system's efficiency. This is not a new approach.

As a health manager, the physician must guide patients in the choice of insurance benefits, encourage use of outpatient services, and stress the importance of health lifestyles. ◀

Herschel Browns M.D.

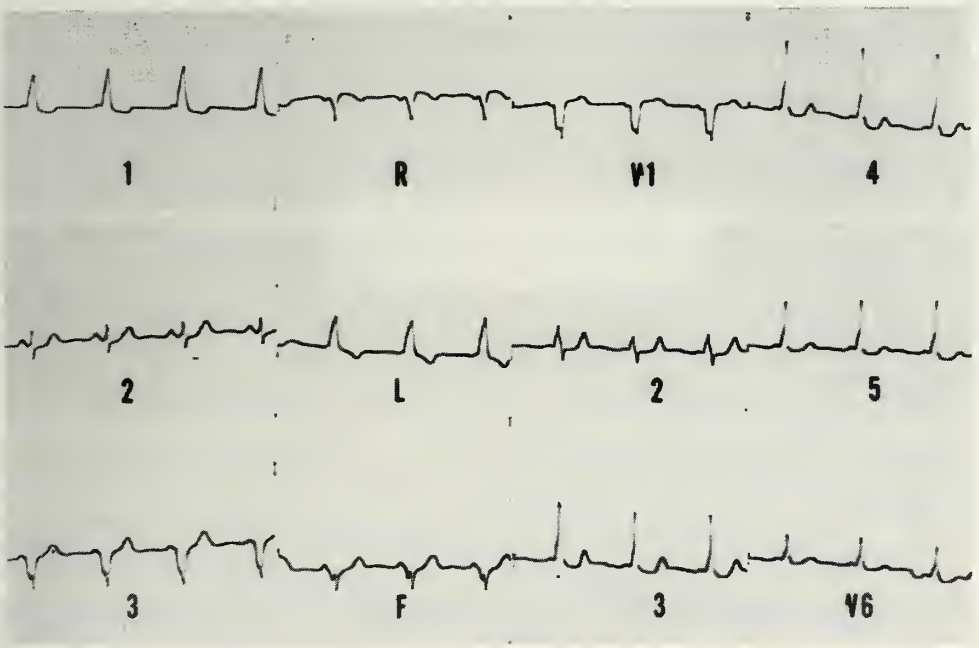
Herschel Browns, M.D., President


In acute
exacerbations*
of chronic
BRONCHITIS
IN ADULTS
*due to susceptible H. influenzae or S. pneumoniae

EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tabin, M.S., M.D., and Ralf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a forty-one year old woman who presents with a complaint of intermittent palpitations. Recent family problems had caused much concern, and at first she thought the palpitations were caused by "nerves". Past medical history was significant only for a vaginal hysterectomy eight months ago. Her physical examination was normal. A blood count, SMA-24, and a chest X-ray were also normal. The twelve lead ECG is shown.



Questions:

1. The twelve lead ECG shows:

A. An inferior wall myocardial infarction.
B. Accelerated idioventricular rhythm with atrioventricular (AV) dissociation.
C. Complete left bundle branch block.
D. Pre-excitation, Wolff-Parkinson-White syndrome.

2. Management of this patient would include:

A. A twenty-four hour ambulatory ECG (Holter monitor).
B. A multistage exercise test.
C. Digitalis.
D. Quinidine.
E. All of the above.

(Continued on page 126)



"EVERY AGE HAS ITS PLEASURES,
ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Desprēaux

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The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology, Deportment of Rodiology, Loyolo University Stritch School of Medicine

This month's Viewbox was contributed by Mark Baker, M.D., department of radiology, Loyola University Stritch School of Medicine.

The patient is a 17 year old white male who developed a cough, headache, and right sided pleuritic chest pain upon returning from a trip to Arizona. Figure 1 was taken 3 weeks after the onset of symptoms. Figure 2 was taken 7 months after first seen.

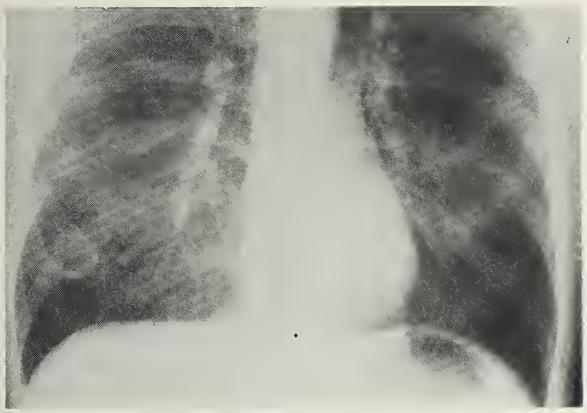


Figure 1
Initial PA chest.

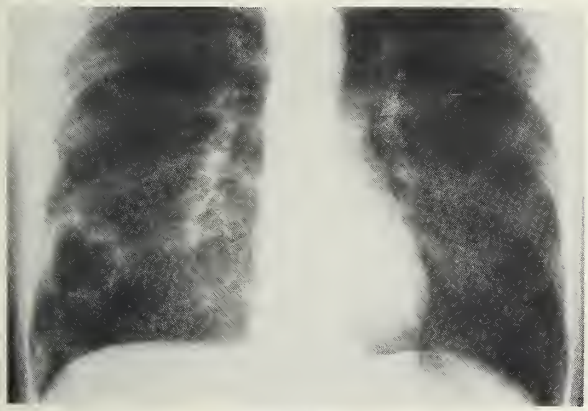


Figure 2
PA Chest 7 months later

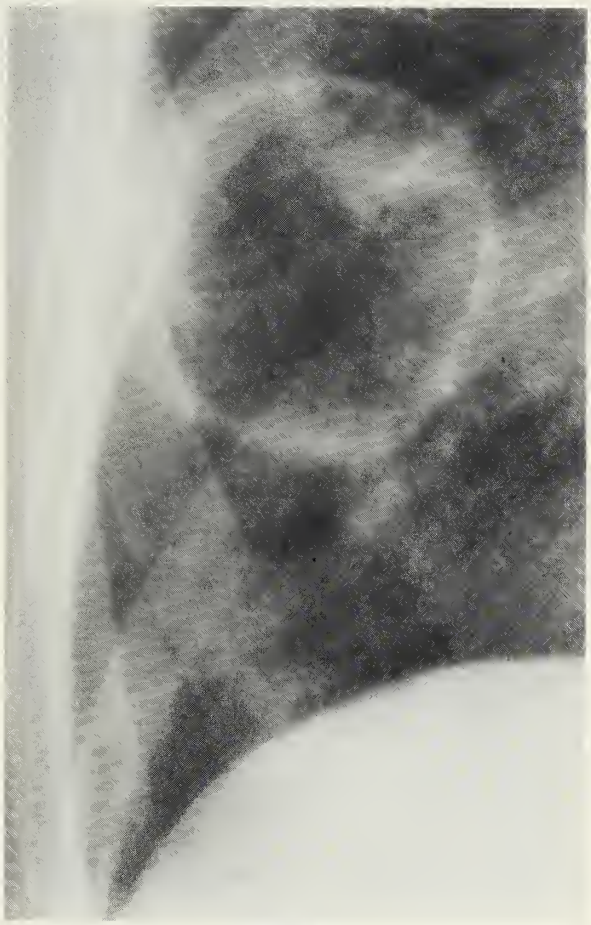


Figure 3
Close-up of RLL lesion in Figure 2.

Your diagnosis?

(1) Atypical tuberculosis
(2) Metastatic malignancy
(3) Coccidioidomycosis
(4) Lung abscess
(5) Histoplasmosis

(Continued on page 115)

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Clinics for Crippled Children Listed for March

Forty-two clinics for Illinois' physically handicapped children have been scheduled for March by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 11 cardiac clinics, one for children with neurological problems and 2 for myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

2 Peoria Myelodysplasia—St. Francis Medical Center
3 Park Ridge Cardiac—AM—Lutheran General Hospital
3 Park Ridge General—PM—Lutheran General Hospital
3 Wheaton General—Marianjoy Rehab. Hosp.
4 Carmi—Carmi Township Hospital
4 Hinsdale—Hinsdale Sanitarium
5 Effingham—St. Anthony Mem. Hospital
5 Lake County Cardiac—Victory Memorial Hospital
6 Division Cardiac—U. of I. at the Medical Center
9 Peoria Cardiac—St. Francis Med. Center
9 Chicago Heights Cardiac—St. James Hosp.
9 Maywood—(Orth/Ped/Neuro)—Loyola Medical Center
10 Carrollton—Boyd Memorial Hospital
10 East St. Louis—Community Hospital
10 Peoria—St. Francis Medical Center
11 Rockford—St. Anthony Hospital
11 Champaign—Urbana—McKinley Health Service Center
11 Chicago Heights General—St. James Hosp.
11 Joliet—St. Joseph Hospital
12 West Frankfort—United Mine Worker's of America—Union Hospital
12 Springfield General—St. John's Hospital
12 Macomb—McDonough Health Department
12 Kankakee General—St. Mary's Hospital
12 Aurora Cardiac—Mercy Center for Health Care Services
16 Maywood—(Orth/Ped)—Loyola Medical Center
17 Rock Island Area General—Moline Public Hospital
17 Alton—Alton Memorial Hospital
17 Decatur—Decatur Memorial Hospital
18 Springfield Ped-Neuro—St. John's Hosp.
18 Evergreen Park—Little Company of Mary Hospital
18 Aurora MM—Mercy Center for Health Care Services
19 Centralia—St. Mary's Hospital
19 Elmhurst Cardiac—Memorial Hospital of DuPage County
20 Kankakee Cardiac—St. Mary's Hospital
23 Peoria Cardiac—St. Francis Med. Center
23 Maywood (Orth)—Loyola Medical Center
23 Chicago Heights Cardiac—St. James Hosp.
24 Peoria—St. Francis Medical Center
25 Elgin General—Sherman Hospital
25 Chicago Heights General—St. James Hosp.
30 Peoria Cardiac—St. Francis Med. Center
31 Belleville—St. Elizabeth's Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Student Business Section in Action

Selling Sex and Cigarettes

This is the third of a five-part series on cigarette advertising

Last month's column described how the tobacco industry and its cronies in Congress have succeeded in blocking any meaningful regulation of cigarette advertising. Cigarette companies have agreed to voluntarily include a health warning and disclosure of tar and nicotine content in cigarette advertisements, (to forestall legislation, regulation, or litigation) but there are no restrictions on the *nature* of cigarette ads. The industry has responded to this freedom by using deceptive advertising that is nothing less than one of the most outrageous (and publicly ignored) scandals of our time.

In 1969, Joseph F. Cullman, a spokesman for the tobacco industry, was asked in Senate hearings about the industry's advertising plans once its commercials were removed from television and radio. He replied that: " . . . it is the intention of the cigarette manufacturers to continue to avoid advertising directed to young persons; . . . not to use testimonials from athletes or other celebrities who might have special appeal to young people; to avoid advertising which represents that cigarette smoking is essential to social prominence, success, or sexual attraction; and to refrain from depicting smokers engaged in sports or other activities requiring stamina or conditioning beyond those required in normal recreation."

These guidelines were never followed before 1969, and they in no way resemble the reality of the situation since then. Like the industry's denials of the health hazards of smoking, they have, in the words of the *New York Times,* "the hollowness of a cough in a graveyard."

The Federal Trade Commission, in its 1978 Annual Report to Congress, identified four main themes used in cigarette advertising:

1. *Minimize Health Risks Theme*—Some ads attempt to minimize anxieties about the risks of smoking in general or smoking a particular brand. For instance, smokers of Newport are "Alive with pleasure." A bride and groom smoking Lark Lights have "a lot of living ahead." Those who smoke Vantage "don't have as many problems with smoking."

2. *Taste, Flavor, Satisfaction Themes*—Regular tar brands emphasize taste as a selling point: "Come to Marlboro Country . . . where the flavor is." Low tar brands often attempt to reassure smokers that, in spite of their low tar and nicotine content, they still taste good. Merit touts a "breakthrough in tobacco science" that "ends (the) struggle to bring taste to low tar smoking." A recent Salem ad suggests that even those who don't enjoy smoking will be won over by the fresh menthol taste: "How come I enjoy smoking and you don't? It's got to be my cigarette. Salem gives me great taste You'd enjoy smoking too, if you smoked Salem."

3. *Positive Personality Themes*—Many ads associate smoking with such positive personality characteristics as individualism, (Camel's "Turk" is "one of a kind . . . at home in a world few men ever see") intelligence, (the "Turk" is at home in "a world where wisdom earns more respect than physical strength") sophistication, (a woman holding a bent Benson & Hedges cigarette proclaims, "I was trying to be sophisticated, and then it happened") youth, ("Winston may not be where you start. But when your taste grows up, Winston is for real") attractive appearance, business acumen, social success, romance, and adventure.

4. *Outdoor and Athletic Activity Themes*—Ads show smokers engaged in almost any sport (*e.g.,* sailing, fishing, biking, horseback riding, football, basketball, skiing, snorkeling, backpacking, kite-flying). According to the FTC, "Such ads imply that smoking is compatible with vitality, physical stress and athletic activity, statements contradicted by the vast wealth of medical evidence." A Christmas ad for Marlboro was described in *Advertising Age* (12/25/78) as follows: "A valley of snow holds a log farmhouse under a blanket of white. Smoke rises in the still air from the chimney. A lone cowboy rides his horse through the untouched virgin snow, dragging a Christmas tree by a rope. It's hard to imagine a more evocative American image, even though

(Continued on page 84)

Guest Editorial

Joint Committee On Administrative Rules

Who We Are and What We Do

BY HON. PRESCOTT E. BLOOM, SENATOR, ILL. 46TH DISTRICT

The citizen can no more escape the tax-gatherer and the policeman in all their protean and multitudinous guises, than he can escape the ultimate mortician. They beset him constantly, day in and day out, in ever-increasing numbers, and in ever-more disarming masks and attitudes.

H.L. Mencken
ON GOVERNMENT

Rules and regulations are important because they affect people in their everyday lives, often more than the laws passed by the legislature. Government regulations can be useful in protecting people and implementing statutes, but regulation must be reasonable and thoughtful. Protecting against unreasonable regulation is what the Joint Committee on Administrative Rules—JCAR, for short—is all about. The sixteen legislators appointed by legislative leaders who comprise the Joint Committee meet monthly to review new rules and regulations.

Each month, the JCAR considers more than a dozen new regulations and gives state agencies our opinion on those regulations. As an oversight committee, we attempt to represent the average citizens of the state as well as the legislature. We try to bring a common-sense approach to our review of new regulations.

The issues are usually very serious. For example, regulations promulgated by the Illinois Commerce Commission imposed a 101-page accounting system on businesses which tow trespassing vehicles. The potential effect of the regulation was to put the small towing companies, such as gas stations, out of business, while not even affecting the large towing companies. In addition, the law which was the basis of the Commission's regulation of the towing company did not authorize imposing such an accounting system. Despite our objections to the rule, the Commission adopted it anyway.

Another regulation proposed by the Illinois Commerce Commission would have prohibited smoking in train stations. The Commission intended to adopt the rule under a law authorizing "protection of the safety" of train passengers. While the regulation might be a good idea, it is clearly beyond the Commission's authority.

Regulations proposed by the Department of Public Health concerning home health agencies also contained serious problems. By requiring administrators and other employees to meet rather stringent educational requirements and by specifying a ratio of nurses to aides, regardless of the specific type of home health services being provided, the Department was simply restricting competition and forcing up costs and prices. Again, large companies supported the rules, while small companies faced serious economic hardships. Under the regulations, even housekeeping services might need to be performed by nurses. Insuring quality care is important, but we need to go about it reasonably and efficiently.

Our principles for reviewing proposed regulations are quite simple: Has the legislature given

Senator Prescott E. Bloom, Peoria, is chairman of the Illinois House-Senate Joint Committee on Administrative Rules. A general trial attorney, Sen. Bloom represents the 46th District in the Illinois State Senate. He has served as Republican spokesman of the Senate Finance Committee and a member of the Appropriations I and Transportation Committees in the Illinois General Assembly.

Sometimes agencies propose rules with language rendering them meaningless or even ridiculous. Consider these gems:

1. An Illinois Commerce Commission rule specifying how to lay pipelines in the oceans of Illinois.
2. A Department of Conservation rule mandating the removal of pet excrement from campgrounds "in a manner approved by the Department."
3. A Department of Public Aid rule providing funds for the burial of amputated limbs, but only for one limb.
4. A Department of Corrections rule for residents of community correctional centers, which allows inmates to go on family outings with volunteer groups, but which "are not to be used for the purpose of family visits."
5. A Pollution Control Board rule requiring a petitioner for a variance to explain federal pollution control regulations to the Board.
6. A Department of Conservation rule requiring all metal grills used in state parks to be inspected and approved by park rangers.
7. A Department of Agriculture rule requiring all odors and insects to be eliminated from loading platforms and collection centers for dead animals.
8. A regulation promulgated by the Illinois Liquor Control Commission which includes commercial airlines in its definition of railroads.

the agency the power to make these regulations? Do they make sense? Will they cost more than they are worth? Are they understandable? Will they actually help the public?

The law which created JCAR requires "the promotion of adequate and proper rules by agencies and an understanding on the part of the public respecting such rules." We have tried to fulfill that purpose by ensuring that rules make sense. Our two major activities promote this purpose: (1) We review each new rule and regulation proposed by every state agency, and (2) we review all old rules and regulations every five years and make "sunset" recommendations.

One regulatory problem we uncovered, which is of particular importance to Illinois' economy, involved rules of the Department of Revenue. The Department had proposed regulations for tax exemptions for buying manufacturing equipment after the General Assembly passed a law exempting these purchases from the state sales tax. The law was designed to stimulate economic development in Illinois; increased industrial activity was expected to more than compensate for the loss of revenue from the exemption. Uncertainty and confusion in the Department's proposed rules made it difficult to determine who was eligible for the exemption. The legislature's intent was further frustrated by the bureaucratic red-tape and delay for processing forms. Industry felt the added paperwork and the manpower needed for its completion were costing more than the tax break was worth. Recognizing these problems, JCAR introduced legislation which revised the sales tax exemption. Legislative intent was strengthened, more clearly defining what is meant by "manufacturing," and reducing the red-tape and paperwork required for claiming the exemption. The Department didn't like it, but we proved that the legislature can be responsive to the need to cut red-tape and make regulations understandable.

The Department of Revenue's proposed rules concerning sales tax on food also misconstrued the legislature's intent, although the practical effect was not as great. The law passed by the legislature had distinguished between sale of food in restaurants and grocery stores—restaurant sales would be charged a higher rate, since they were considered more of a luxury. Instead of trying to distinguish between food sold for immediate consumption on the premises and food to be taken home, the Department decided to base the tax on whether the food was hot or cold. Imagine what that does to a delicatessen selling hot and cold corned beef sandwiches, a grocery store with a snackbar, or bakery which sells loaves of bread while they're still hot.

One final example: The Department of Revenue proposed rules to require that sales tax returns be verified under a penalty of perjury. Only a few months before, the Department had vigorously supported a bill with almost identical language which the House had rejected. The Department was attempting to do by rule exactly what was not authorized by statute.

These examples come from our review of new regulations, but our "sunset review" for existing rules is also a large task. The total existing rules in Illinois which we must review take up 40,000 pages. By 1984, we will have gone through each of these 40,000 pages and hopefully convinced agencies to eliminate the regulations which are unnecessary, duplicative, or improper. We are already well into the first cycle of this project.

The workload of JCAR can be grasped by looking at some of our accomplishments during our first two years of operation. We reviewed over 500 proposed rules in 1978, some of which ranged up to 1000 pages in length; a total of over 12,500 pages of proposed rules were analyzed during 1978 and 1979. Of these hundreds of rules, JCAR issued formal objections to over 150 proposed rules and many other serious problems were corrected through the agencies' cooperation.

During 1978, JCAR discovered serious problems in almost 200 proposed rules; in 1979, serious problems were discovered in almost 400—nearly 50% of all the proposed rules reviewed. Emergency rulemaking, which agencies use to avoid public input, has been significantly reduced as a result of JCAR scrutiny.

We are trying to make state government regulations less burdensome, to open the state regulatory process to public scrutiny, to insure that laws enacted by the legislature are not violated by improper regulations, to eliminate unnecessary regulations, and to make regulations easier to understand. Our goal is to make bureaucracy more responsive to, and more effective for the citizens of Illinois. ◀

SBS

(Continued from page 81)

the white boxed cancer warning in the right hand corner has stained the snow yellow. The reflective pleasure of tobacco pervades the ad. It unifies the desire for a perfect Christmas with the experience of smoking. The Surgeon General has no chance against this."

The beguilement that Madison Avenue and its tobacco clients will use to sell cigarettes knows no limits. It should be clear that they have carefully researched their market, as well as the methods optimally suited to recruit new smokers. According to Maurine Neuberger in SMOKE SCREEN: TOBACCO AND THE PUBLIC WELFARE, the industry has even hired Freudian psychologists as ad consultants. A cartoon that appeared in the *London Spectator* shortly after the momentous British Royal College of Physicians' Report on Smoking and Health in 1962, poked fun at the preoccupation of cigarette advertisers with Freudian symbolism. Two troubled ad men are speaking. One, shrugging, says resignedly, "O.K., we'll drop the sex angle and play up the death wish." ◀

Ronald M. Davis, Delegate, ISMS-SBS

ANNUAL MEETING

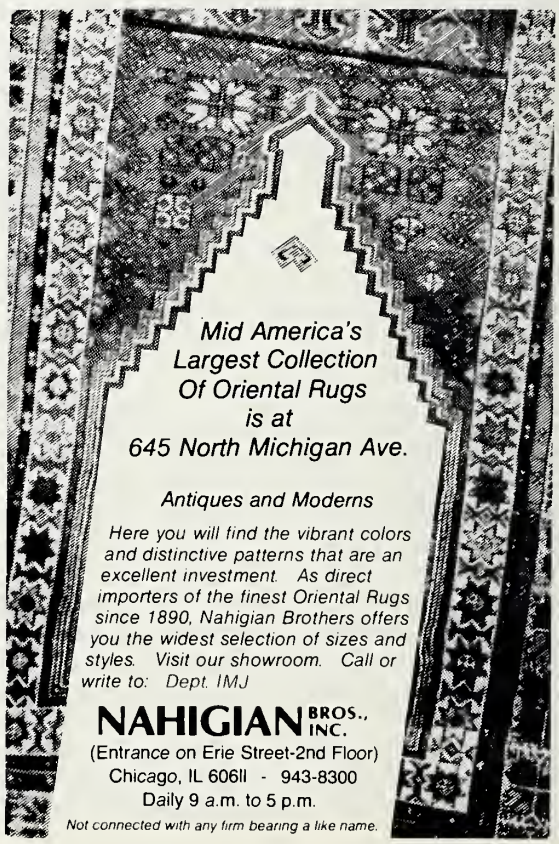
ISMS HOUSE OF DELEGATES

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The ISMS House of Delegates will convene April 5, 1981. Concurrent educational programs, which begin on Saturday, April 4, 1981, will include the following:

Competition through Alternative Delivery Systems
Substance Abuse: Clinical Aspects
Medicine in the 1990's
Loss Prevention

A complete program will be published in the March issue of *IMJ*. For further information, please contact the ISMS offices: 55 E. Monroe, Suite 3510, Chicago IL 60603; (312) 782-1654.



OBITUARIES

****Arendt, Erna L.,** Chicago, died January 11, 1981, at the age of 76. Dr. Arendt was a 1929 graduate of Friedrich-Wilhelms University Faculty of Medicine, Berlin, Germany.

***Bonnie, Samuel Emanuel,** Springfield, died November 20, 1980, at the age of 68. Dr. Bonnie was a 1940 graduate of the Loyola University Stritch School of Medicine.

****Foran, Francis L.,** Chicago, died December 24, 1980, at the age of 90. Dr. Foran was a 1917 graduate of Rush Medical College.

***Kroulik, William J.,** Chicago, died January 9, 1981, at the age of 68. Dr. Kroulik was a 1938 graduate of the Chicago Medical School.

***Rauwolf, Andrew Paul,** Mattoon, died October 16, 1980, at the age of 69. Dr. Rauwolf was a 1936 graduate of the Loyola University Stritch School of Medicine.

****Scatliff, H. Kenneth,** Chicago, died January 3, 1981, at the age of 91. Dr. Scatliff was a 1913 graduate of Hering Medical College.

****Tucker, Joseph,** Levcadina, CA., formerly of Chicago, died January 3, 1981, at the age of 74. Dr. Tucker was a 1929 graduate of the Northwestern University School of Medicine.

***Turchan, John James,** Westchester, died December 14, 1980, at the age of 53. Dr. Turchan was a 1954 graduate of the Loyola University Stritch School of Medicine.

* Indicates ISMS member
**Indicates ISMS member of the fifty year club

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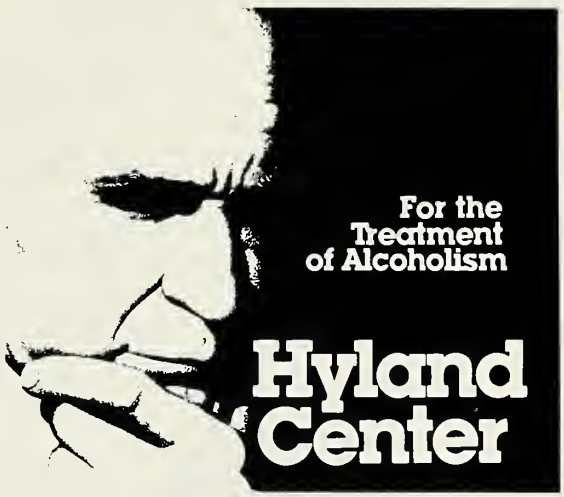
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Chicago Pediatric Society
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Chicago Radiological Society
Chicago Surgical Society
Chicago Urological Society
Chicago Society of Internal Medicine
Chicago Society of Plastic Surgery
Chicago and Illinois Society of Anesthesiologists
Cook County Council of Allergy and Clinical Immunology
Illinois Chapter, American College of Chest Physicians
Illinois Chapter, American College of Emergency Physicians
Illinois Chapter, United States Section International College of Surgeons
Illinois Society of Physical Medicine and Rehabilitation
Illinois State Medical Society—Resident Section
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Lithuanian Medical Association
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IMPAC REPORT

The IMPAC Council believes that you, the members of IMPAC, should be aware of your political action committee's successes and failures. Therefore, listed below by category are the contributions made by IMPAC toward the November general elections. In total, IMPAC was involved in 216 state and federal campaigns, distributing $142,150 of membership contributions. Please that these figures are for the general election only and do not include contributions made toward the primary election.

	CONTRIBUTIONS	CANDIDATES SUPPORTED	WON/LOST	WINNING PERCENTAGE
ILL. STATE SENATE	$16,400	28	25/3	89%
ILL. HOUSE	$75,300	162	154/8	95%
U.S. HOUSE & SENATE	$42,250	18	14/4	78%
SUPPORT FOR OTHER ELECTED OFFICIALS*	$ 8,200	8	NA	NA
TOTALS	$142,150	216	193/15	89%

*Includes support for incumbents not up for re-election.

I am proud to note that, as you can see, our successes were many and failures few. Hopefully, seeds planted in the general elections of 1980 will grow to produce quality health care legislation in years to come.

But the job never ends. Under current Illinois law, the next primary election for our Representatives and Senators in Springfield and Washington is only a year away! We must begin working toward that election today.

Thank you for your past efforts to strengthen medicine's political arm. Please continue to support your PAC, IMPAC--The Illinois State Medical Society Political Action Committee.

P.F. Mahon MD

Chairman

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates fo federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society no the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPA reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to th limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with th State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield Illinois 62704.

IMJ
Illinois Medical Journal
Vol. 159, No. 2, February, 1981

A Limited Experience with Radiotherapy

Can Something Be Done For Metastatic Malignant Liver Disease?

By VIRENDRA S. SAXENA, M.D., D.M.R.T., F.R.C.R. (LOND.), EKACHAI VISETSIRI, M.D., PRAMILLA SARIN, M.D. and HAM-NYUNG LEE, M.D./OAK LAWN

Metastatic spread to liver from malignant tumor is frequent, difficult and frustrating to manage. It is also one of the most ominous signs of advanced malignancy. The purpose of this study is to evaluate the role of palliative radiotherapy in alleviating symptoms of liver metastasis and improving the quality of life for these patients.

Twenty-two patients with metastatic malignant disease of the liver were seen between January 1977 and March 1980. Their age and sex distribution is given in Table 1. In most instances the metastatic disease in liver arises from gastro-intestinal adenocarcinomas.[1,2] In our series of 22 patients, 13 had primary carcinomas arising from colon, rectum, stomach and pancreas. (Table 2).

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The Clinical Picture

The liver metastasis may be present without symptoms or signs in many patients. However, common symptoms from liver metastatic malignancy are pain either in right upper quadrant or upper abdomen, jaundice, anorexia and ascites.[1]

In the present series, 16 patients' first symptom was pain. (Table 3) Fifteen patients had clinical hepatomegaly. Jaundice occurred in only three patients. Anorexia and weight loss were not documented. Alkaline phosphatase and serum glutamic oxalacetic transaminase (SGOT) as well as total bilirubin may all be elevated in earlier stages of hepatic involvement and sometimes even before the disease is apparent on scintiscans of liver. This was shown in the present series, where half had elevated alkaline phosphatase and eight of 22 and 13 of 22 had elevation of total bilirubin and S.G.O.T. respectively. (Table 4).

At present, radio-isotope liver scan remains the most frequent procedure to evaluate filling defects or cold areas in this organ.[3] Of 22 patients

Table 1

Total Patients Seen	22
Age	41 Yrs.-85 Yrs.
Males	11
Females	11

Table 2

Primary Sites of Malignancy

G.I. Tract	13
Breast	4
Lung	4
Malignant Melanoma	1

Table 3

Clinical Findings

Finding	Present	Absent	Not Documented
Hepatomegaly	15	3	4
Pain	16	4	2
Jaundice	3	19	0

Table 4

Investigations

OF PATIENTS

Test	Abnormal	Normal	Not Done
Alkaline Phosphatase	10	10	2
Total Bilirubin	8	12	2
SGOT	13	7	2
Liver Scan	19	0	3
Biopsy	1	0	21

in present series, 19 had liver scans. (Table 4) In each there were findings consistent with metastatic malignant disease in the liver, including cold regions and irregular enlargement.

Hepatic angiograms are rarely done but could be useful in some patients.[4] As far as ultrasound examination of liver in this situation is concerned, metastases usually produce weak echos. The same tumors, interestingly, would sometimes produce strong echos shortly after initiation of chemotherapy or radiotherapy.[5] It is suggested that the latter findings could be utilized in evaluating response of disease of these modalities of treatment.[5] In present series, none of these diagnostic procedures were employed.

Management

Fourteen of the 21 patients in this series had prior chemotherapy for their metastatic disease. Thus, eight patients reported no previous therapy. (Table 5)

Table 5

Prior Therapy

Chemotherapy	14
No Therapy	8

Table 6

Dose of Radiation to Liver*

Less than 2000 Rads	2
2100-2400 Rads	3
2500-3000 Rads	13
More Than 3100 Rads	4

*200-300 Rads Per Day and Five Times a Week

All 22 patients received radiotherapy to whole liver from Cobalt 60 gamma rays. Most (13 of 23) were given between 2500 rads and 3000 rads to the liver. The fraction size varied from 200 rads to 300 rads per day. They received five treatments per week. (Table 6)

Tolerance to radiotherapy was good and all completed their therapy without interruption. None complained of persistent nausea, vomiting or upper abdominal cramps requiring medication.

Results

Response to radiotherapy for hepatic metastasis was judged as "good", "satisfactory" and "poor or no response." Factors used to determine were: (a) reduction of more than 75% of pain; (b) improvement in serum chemistry including alkaline phosphatase, total bilirubin and SGOT; (c) improvement in liver isotope scan; (d) reduction in the size of the liver and (e) improvement or complete disappearance of jaundice.

The criteria used to define the quality of response were as follows: (a) "Good response"—Reduction of pain and improvement of at least two other factors as described above; (b) "Satisfactory response"—Improvement in pain or improvement of at least one other factor and pain or (c) "Poor or no response"—Persistence of pain with or without improvement in any other factors following radiotherapy course.

Using the above criteria to judge response to radiotherapy it was found that, of 22 patients, nine or 41% had "good responses," and 20 or 91% had "satisfactory responses." Only two of these patients showed "poor or no response" to radiotherapy. (Table 7)

Three patients had jaundice before therapy. In two of these, the jaundice disappeared.

Average survival following therapy was 101

Table 7

Response To Radiotherapy
Total Patients 22

Response	# PTS.	Percentage
Good	9	41%
Satisfactory	20	91%
Poor Or No Response	2	9%
Total	22	

days. One patient survived one year and ten patients over 90 days.

Discussion

Management of patients with hepatic metastasis is difficult, challenging and often frustrating. Frequently, the patient is riddled with metastatic disease in various parts of the body and management merely consists of keeping the patient comfortable in the last days of life. Some patients, however, complain of progressive pain, jaundice, upper abdominal discomfort, G.I. upsets, etc. There are various modalities available to these patients including surgery, chemotherapy and radiotherapy.

Surgical excision of a solitary metastasis in liver has been done, but is generally discouraged.[6,7] The hazards of surgical excision of a part of liver are great—and benefits are few. There is a danger of uncontrolled bleeding and infection. However, some authors[8] have attempted a near total or total resection with homograft of liver. This, at present, is highly experimental and probably controversial. A partial hepatectomy may be attempted in a few highly selected patients with solitary metastasis.

Another surgical approach in management of malignant liver metastasis has been hepatic artery ligation alone.[9] This possibly produces ischemia and necrosis in tumor and reduces the size of metastasis. It has a limited application because of its rather poor overall results and high morbidity, complications and even mortality.[9]

Systemic chemotherapy might be of some value in these patients but suffers from a rather poor response from metastatic tumors, most of which originate from gastro-intestinal tract. A commonly used chemotherapeutic drug is 5 Floururacil. 5 F.U., as it is popularly called, was first introduced in clinical use in 1957.[10] It has now become a mainstay of chemotherapeutic management of G.I. tract malignancies.[11] It has been known to cause objective reduction in tumor size in about 15-25% of patients with G.I. tract malignancies.[10,12,13] The lives of a few patients could possibly be prolonged by chemotherapy, especially those who initially respond to it. While the total number is small, there are some patients with hepatic metastasis in whom life has been prolonged significantly by its use. 5-Floururacil can be given either parenterally or orally on weekly intervals. Sometimes it is given in the form of continuous intravenous infusion in 120 hours.[14] The results of these two methods of giving 5 F.U. in this malignancy are probably not much different, but it seems that the continuous infusion method may be less toxic.[14] Oral administration of 5 F.U. is less effective but is certainly more convenient to the patient.[15,16] Some authors [17, 18] believe that oral 5 F.U. may be more effective against hepatic metastatic disease from G.I. tract to malignancies than the parenteral drug. This however, may not be wholly reproducable in other studies.

Other chemotherapeutic drugs used in disseminated malignancies are nitrosoureas. These include BCNU, CCNU, and methyl CCNU. These are used mostly in combination with 5 F.U. and other drugs like Adriamycin, Vincristine, DTIC, etc., with varying success.[19]

Hepatic artery ligation with post-operative chemotherapy has also been described with relief of symptoms in 57% of patients with hepatic metastases from colon cancers.[20] Mean survival of these patients was 27 weeks. A 60% improvement was reported by Ansfield[21] in 113 patients with liver metastases by intra-hepatic arterial infusion of 5 Floururacil.

Role of Radiation Therapy

Radiation therapy has been used rather sporadically and without much popular support in the literature. However, in recent times its use in hepatic metastases has been evaluated.[1,22] This study tends to support the findings of some recent studies[1,22,23] that hepatic metastases could be managed effectively with doses of between 2000-3000 rads in 2-3 weeks' time. The main symptoms of pain and anorexia are relieved in about 70% of the patients.[1] In about 50% the blood chemistry shows improvement.[1,23] In a small number, the jaundice also shows signs of improvement.[1] In about 35% the liver size shows signs of reduction.[1,22] Similar results have been observed by the authors of this study and others in literature.[23,24]

Summary

Hepatic metastases from malignant disease are frequent. These pose problems of pain, anorexia, weight loss, jaundice and ascites in these patients.

Though in the past it was hard to manage symptoms of hepatic metastatic disease, there is now some evidence that it can be done with a carefully administered radiation therapy in selected symptomatic patients.

About 90% of patients are helped effectively. Surgery and chemotherapy have also been used in management of these patients but these two modalities have not been uniformly effective. However, they could be reserved for a few selected patients. Radiation therapy given properly and with proper fractionation carries little morbidity and complications. A study of 22 patients with metastatic malignant disease of liver seen at one institution in slightly over two years is presented. An attempt is made to document evidence that a short palliative course of radiotherapy for these unfortunate patients is a worthwhile effort in improving quality of their limited lives and without any increase in morbidity. ◀

References

A complete list of references for "Can Something be Done for Metastatic Malignant Liver Disease: A Limited Experience with Radiotherapy," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

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Laboratory Diagnosis In Thyroid Disease

By Vincent Lopez-Majano, M.D. and C. Abraira, M.D., F.A.C.P./Chicago

Laboratory diagnosis will help the clinical observations in assessing the functional status of the thyroid gland. Tests that measure directly circulating thyroid hormones (T4 by binding competition and T3 by radioimmunoassay) or indirectly by measuring thyroidal binding sites in plasma (T3 resin uptake) will be complemented by determination of the hypophyseal thyroid stimulating hormone (TSH). Elevation of TSH in plasma will be an early and sensitive indicator of primary hypofunction of the thyroid (the target gland). Lack of TSH response after thyroid releasing hormone (TRH) injection will denote thyroid gland autonomy in suspected hyperthyroidism. The use of these last two tests has largely replaced the TSH stimulation, iodine uptake and thyroid suppression tests with T3 in the evaluation of thyroid gland function. Nevertheless, these tests are still useful in determining status of the diffusely enlarged gland—especially thyroid nodules. Associated with radioiodine uptake and scintigrams, they help in the diagnosis of malignant or benign lesions. In the first case, radioactive uptake and scans also can identify functioning metastases.

Thyroidal antibodies in conjunction with the other thyroid function tests will assist in the diagnosis of chronic thyroiditis. Elevated blood calcitonin is a useful hormonal marker of medullary carcinoma of the thyroid. Serum calcium and alkaline phosphatase, lipid profiles, hematological cell values and sedimentation rate may be nonspecific adjuvant tests that contribute to the characterization of thyroidal disease.

Thyroid diseases can affect the form, size, structure or function of the thyroid gland and also produce systemic manifestations.

The clinical history and a careful examination can inform about local disease manifestations, such as enlargement of the thyroid gland, presence of nodules and general findings such as tachycardia, hyperreflexia and weight alterations.

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Thyroid Function Tests[1]

The clinical diagnosis should be correlated with objective studies (Table 1). Marked alterations of the thyroid function are easily suspected clinically. However, when the extent of disease does not correlate with objective data, the degree of severity is better established by objective tests. These include blood T3 and T4 and radioactive iodine uptake. The numerical information provided by these tests can be a useful index to study in conjunction with clinical findings and therapeutic response. Scintigraphy with the appropriate radionuclide, thermography, and ultrasound can inform about the size and function of the gland.

Thermography is useful in diagnosis of hyperthyroidism. There are no contraindications to the use of thermography and ultrasound in the study of the thyroidal structure because these methods do not produce ionizing radiation. On the other hand, ionizing radiations are produced when radionuclides are used in the patient. This contraindicates their use in pregnancy.

The thyroid can be visualized with fluorescent scanning without any radiation exposure.

The radioiodine uptake is a very sensitive test which can be affected by many drugs, foods and

TABLE 1

INDICATIONS FOR THYROID TESTS

	T_3 resin uptake	T_4	Thyroid anti-bodies	Suppres-sion Test	LATS	SERUM TSH	Radio-iodine uptake	Thyroid Scan	Ultra-sound	Thermo-graphy
Screen for thyroid disease	+	+				+				
Hyperthyroidism	+	+	+		+		+	+		+
Nodules	+	+	+	+			+	+	+	+
Nodules with clinical hyperthyroidism	+	+	+	+			+	+	+	+
Goiter (simple)	+	+	+				+	+	+	+
Retrosternal goiter	+	+	+				+	+		
Thyroiditis	+	+	+			+	+	+		
Thyroid Surgery	+	+	+			+	+	+		
Thyroid carcinoma										
1) Before surgery	+	+				+	+	+	+	+
*2) After surgery	+	+				+	+	+		+
Struma ovaril	+	+					+	+		
Vocal cord paralysis	+	+					+	+		

**Whole body scan to search for metastases and bone scintigram to seek non-functioning metastases*

diagnostic tests, especially those containing iodides (Table 2). To be able to perform radioiodine uptake and thyroid scans with radioiodine, it is necessary to stop for some time all the medications seen in Table 2. IVP and gallbladder series interfere with radioiodine uptake to such an extent that thyroid scintigraphy with radioiodine can not be performed until 1-3 months after the X-ray test. Bronchography and myelography with iodine-containing contrast media can interfere with iodine uptake for a year or more. However, thyroid scintigrams can be obtained with Tc-99m because this radionuclide is trapped by the thyroid unless extraordinary amounts of iodine or other interfering drugs are administered before thyroid scintigram. None of these drugs interfere with ultrasound and thermography studies of the thyroid gland.

The correct interpretation of the 24 hour radioiodine uptake test has been hampered by progressive decline in normal values observed in the last few years, due to the several fold increase in daily iodine ingestion by the U.S. population. It no longer discriminates for hypothyroidism and many cases of unquestionable hyperfunction show uptake levels that overlap normal range. The 24 hour RAI test is, however, useful in identifying factitious hyperthyroidism, struma ovarii, subacute thyroiditis with thyrotoxicosis and iodine-induced hyperthyroidism. All of these conditions will be associated with very low thyroid uptake. In addition, it assists in the calculation of therapeutic I^{131} doses, and is necessary for the stimulation and suppression tests described below.

Tests That Measure Circulating Hormone Status

Thyroid function can be assessed with *in vitro* determination of the T_3 and T_4 concentration without any risk to the patient. The two "T_3 tests" differ in their significance and interpretation. One, the *in vitro* resin uptake of labelled T_3 or triiodothyronin, is an indirect measurement of thyroxin binding sites in plasma.[2] The other test, also called T_3 RIA, or radio immunoassay, involves the direct determination of blood concentrations of one of the thyroid hormones, triiodothyronine. Serum T_4 or thyroxine concentration may be directly determined by competitive protein binding assay. In general, both of these values will change in direct correlation with functional status of the thyroid gland. Exceptions to this rule will be detected by concomitant determination of T_3 resin uptake.

The T_3 resin uptake (T_3RU), expressed as percentage values, changes in direct relation to thyroid hormone concentration in the blood or in inverse correlation to levels of thyroid binding globulins. Thus, it has to be interpreted together with serum T_4 concentration, and T_3 resin uptake might be in discordance. In such a case the resulting abnormalities can be assessed with determinations of the resin uptake of T_3 and plasma T_4

TABLE 2
INTERFERENCE WITH RADIOIODINE UPTAKE

A. Causes of erroneous low iodine uptake

Iodine containing compounds	*Time of interference*
GENERAL PREPARATIONS	
Lugol's solution	1-3 weeks
Iodides	1-3 weeks
Antitussives	1-3 weeks
Iodine ointments (topical)	1-3 weeks
Iodine tincture (topical)	1-3 weeks
Iodoform (topical)	1-3 weeks
Iodine suppositories	1-3 weeks
Vitamin preparations (occasional)	1-3 weeks
Entero-Vioform	1-3 weeks
Diodoquin	1-3 weeks
Enterosept	1-3 weeks
Penicillin	1-3 weeks
CONTRAST MEDIA	
Aqueous Solutions	1-3 months
Diodrast	1-3 months
Hypaque	1-3 months
Mediopaque	1-3 months
Neo-Iopax	1-3 months
Urokon	1-3 months
Miokon	1-3 months
Thixokon	1-3 months
Renografin	1-2 weeks
Dionosil (British)	2-4 months
Oily Solutions	
Lipiodol	1 year or more
Visciodol	1 year or more
Ethiodol	1 year or more
Iodochlorol	1 year or more
Pantopaque	1 year or more
Cholecystopaques and Cholangiopaques	
Cholografin	3 months
Telepaque	2 months
Priodex	1-3 months
Utersalpingopaque	1-3 months
Skiodan acacia	1-3 months
Salpix	1 month

Other chemicals and drugs	*Time of interference*
Antithyroid drugs	2-8 days
Thiouracil	2-8 days
Propylthiouracil	2-8 days
Methylthiouracil	2-8 days
Iothiouracil (Itrumil)	2-8 days
Muracil	2-8 days
Methimazole (Tapazole)	2-8 days
Mercazole	2-8 days
Carbimazole	2-8 days
Thyroid medication	1-2 weeks
Disiccated thyroid (T_3, T_4)	1-3 weeks
Thyronine	1-3 weeks
Thyroxine	1-3 weeks
Thiocyanates	1 week
Perchlorates	1 week
Nitrates	1 week
Sulfonamides	1 week
Progesterone	1 week
Adrenal Cortical Steroids	1 week
ACTH	1 week
Resorcinol	1 week
Cobalt	1 week
PAS and Isoniazid	1 week
Butazolidin	1 week
Antihistamines	1 week
Phenothiazine	1 week
Pentothal	2-3 days
Phenobarbital	2-3 days
Diuretics	2-3 days
Tolbutamide	2-3 days
Anticoagulants	2-3 days
Salicylates	2-3 days

B. Causes of erroneous high iodine uptake

	Time of interference
Thyroid stimulating hormone	3-6 days
Iodine deficiency	Until corrected
Recently discontinued antithyroid drugs	3-6 days

C. Some extrathyroid causes of interference with serum T_4 and T_3 resin uptakes.

	serum binding proteins	T_4	T_3 *RU*	T_7 *(FTI)*
Pregnancy	↑	↑	↓	=
Estrogens	↑	↑	↓	=
Oral contraceptives	↑	↑	↓	=
Hyperalbulinemia	↑	↑	↓	=
Acute hepatitis	↑↑	↑	↓	=
Low thyroid binding globulin	↓	↓	↑	=
Steroids (high dose of cortisone & analogues)	↓	↓	↑	=
Acromegaly	↓	↓	↑	=
Hypoalbuminemia	↓	↓	↑	=
Nephrosis	↓	↓	↑	=
High thyroid binding globulin	↑	↑	↓	=
Salicylates (high dose)		↓	↑	
Androgens or anabolic steroids	↓	↓	↑	=
Dilantin	=	↓	↑=	↓=
Triiodothyronine (replacement dose)	=	↓	↑	↓
Dessicated thyroid (replacement dose) (T4 + T3)	=	=↓	=	=
Levothyroxine (T4 replacement dose)	=	=↑	=	=

together. From these two, a free thyroxine index can be devised:

$$FTI\ (T_7) = \frac{\text{resin uptake}\ (\%)}{100} \times T_4.$$

Each laboratory has a standard range of normal values for FTI.

Peripheral conversion of T_4 into T_3 occurs normally.[3] Such conversion is decreased in non-thyroid diseases, (renal failure, starvation, cirrhosis, corticosteroid administration, etc.) giving low circulating T_3 values. However, direct T_3 serum determination is invaluable in diagnosis of T_3 thyrotoxicosis, in which the T_3 RU and T_3 RIA are increased and the T_4 and TBG are normal. (In this case the thyroid suppression test described below is abnormal too). The determination of T_3 by radioimmunoassay is also useful in early hyperthyroidism in which the first laboratory abnormality present might be increased T_3 circulating levels.

When borderline low values of thyroid functions are obtained, direct blood determination of thyroid stimulating hormone (TSH) is indicated; if elevated it will confirm primary thyroid gland hypofunction. If low, secondary hypothyroidism is suspected. In this case, administration of TRH (TSH releasing factor) will identify whether the pituitary (after TRH injection no elevation of TSH) or the hypothalamus (normal TSH discharge after TRH injection) are at fault. The administration of medications and extrathyroid conditions may interfere with T_4 and T_3 resin uptake.

The TSH Stimulation Test is rarely applied for evaluation of hypothyroidism because of cardiovascular effects in the elderly and allergic problems. Also, its primary indication, differentiation of primary (target gland) thyroid insufficiency from secondary (pituitary failure) hypothyroidism, is easily diagnosed by radio-immunoassay measurement of circulating TSH.

Thyroid Suppression Test with T_3 or T_4

Administration of thyroid hormone for six to eight days will suppress TSH and activity of normal thyroid gland but not of hyperfunctioning thyroid. This is a very useful test when diagnosis of hyperthyroidism is questionable, such as in T_3 hyperthyroidism in which abnormally high T_3 levels are associated to normal T_4 and radioiodine uptake (RAIU), iodine-induced thyrotoxicosis, and even in acute or subacute thyroiditis, unless radioiodine uptake is low from the outset. However, evaluation of thyroid gland autonomy can be achieved more safely with intravenous injection of 500μgm of thyrotropin releasing factor (TRH). This test accomplishes the equivalent of a thyroid suppression test without the possible risks of thyroid hormone administration; the lack of circulating TSH elevation after administration of TRH will confirm pituitary suppression by a hyperactive thyroid gland.

The indications for these tests can be found in Table 1. The results of all thyroid function tests, including thyroid scintigraphy, should be interpreted together and in conjunction with the clinical findings.

Autoimmune Antibodies in Thyroid Disease

There are two main types of thyroid antibodies used in clinical diagnosis: one against thyroglobin (TGHA) and antithyroid cell microsomes (MCHA). MCHA is positive in 87% of the cases of Graves' disease and in 85% of Hashimoto's disease. In this disease the TGHA is positive only in 58% of the patients; TGHA is positive in 25% of patients with Graves' disease. These tests are positive in about half of patients with "idiopathic" primary hypothyroidism.

It is noteworthy that low titers of these antibodies are found in 20% of normal adult women. Positive titers of 1:2560 or higher are consistent with the presence of Hashimoto's disease or lymphocytic thyroiditis.

Long-acting thyroid stimulator (LATS) is an abnormal gamma globulin with action roughly similar to that of TSH. It is present in 30-40% of patients with Graves' disease; its presence is pathognomonic of this disease, but will not correlate with thyroid functional status. Thus, it might be detected years before, during or even after true hyperthyroidism is detectable.

Alterations of Function (Table 3)

Hypothyroidism: Lethargy, somnolence, weight gain, pretibial edema and increased sensitivity to temperature changes are characteristic findings of hypothyroidism. The diagnosis of this entity can be established if the serum T_3, T_4, T_3 resin uptake and radioiodine uptake are low.

Hypothyroidism can result from surgery or radioiodine treatment; it is often secondary to chronic thyroiditis such as Hashimoto's. Serum TSH will be high if there is primary gland failure and low if the hypothyroidism is of pituitary primary origin.

Hyperthyroidism: Tachycardia, weight loss, intolerance to heat and nervousness are hallmarks of severe hyperthyroidism. These symptoms are not necessarily present in every patient and they can result from diseases other than hyperthyroidism. Hyperthyroidism can present as Graves' disease, toxic multinodular goiter and

Table 3

THYROID FUNCTION TESTS

	Normal Values	Hyperthyroidism Grave's Disease	Hyperthyroidism Autonomous Nodule	Hypothyroidism 1 ary	Hypothyroidism 2 ary	Non Toxic Multi-Nodular Goiter	Thyroiditis subacute	Thyroiditis Hashimoto disease
Measurement of Hormone Concentration And Its Transport In Blood								
a. Protein-bound iodine (PBI)	4-8 μg 1/100 cc	↑	↑=	↓	↓	=	↑=	=↓
b. Butanol-extractable iodine (BEI)	3.5-6.5 μg 1/100 cc	↑	↑=	↓	↓	=	↑ =	=↓
c. Total serum thyroxine (TT_4) by radioligand	4.2-9.4 μg/100cc	↑	↑=	↓	↓	=	↑ =	=↓
d. Total serum trilodothyronine (TT_3) by radioligand assay	90-160 μg/100cc	↑	↑=	↓	↓	↑=	↑ =	↓=
e. Resin T_3 uptake (RT_3U) test	25-35%	↑	↑=	↓=	↓=	=	↑ =	=↓
f. Thyroxine-binding globulin (TBG) capacity	16-24 μg/100 cc	↑=	↑=	↓=	↓=	↑↓=	=	=
g. Thyroxine-binding prealbumin (TBPA)	22-300 μg/100cc	↑=	↑=	↓=	↓=	↑↓=	=	=
h. Free T_4 (FT_4)	.03-.045%	↑	↑=	↓	↓	=	↑ =	↓=
i. Free T_3 (FT_3)	.22-46%	↑	↑=	↓	↓	↑↓=	↑ =	↓=
j. Free thyroxine index (FTI)	1.7-5.5	↑	↑=	↓	↓	=	↑ =	=↓
Evaluation of the Integrity of the Feed-Back Mechanisms Regulating Thyroid Gland Function								
a. Serum thyroid stimulating hormone (TSH) or thyrotropin concentration	1-15 μU/cc	↓=	↓	↑	↓	=	=↓	↑=
b. Thyrotropin-releasing hormone stimulation test of TSH	<15 μU over basal TSH	↓	↓	↑	↓	↑	=↓	↑ =

toxic autonomous nodule. More rarely, Hashimoto's thyroiditis, struma ovari, T_3 toxicosis and functional metastasis from follicular carcinoma can produce hyperthyroidism.

The main tests to be performed are seen in Table 1. The need for these studies is to establish the diagnosis of hyperthyroidism, obtain a baseline of function before treatment and calculate dose of radioiodine for hyperthyroidism therapy.

The follow-up of patients with hyperthyroidism after radioiodine therapy may be done with circulating T_4 T_3 and RAIU. The RAIU might be obtained also in 5-6 weeks. Overtreatment is detected as hypothyroidism. High TSH level is the most sensitive early indicator of this complication. Patients on other types of therapy should be studied every three months in the first and second year and yearly thereafter. Hyperthyroidism often ends up in hypofunction of the gland, even without surgery or radioiodine therapy, probably resulting from autoimmune processes.[4]

Alterations in Structure or Size of the Thyroid Gland (Table 4)

Alterations in the size of the thyroid and presence of nodules may be determined by history and palpation; the degree of hardness and mobility of the thyroid and its nodules can be established if they are within the palpable range. They can be hard, soft, mobile, immobile and/or easily displaced.

Thyroid scintigraphy is based on activation of the iodine contained in the thyroid gland or by administration of radioiodine with adequate energy for external detection. 131_I and 123_I are used for this purpose. Scintigraphy permits visualization of uptake defects in the thyroid gland; there are the so called "cold" nodules which may result from hemorrhages, cysts or neoplasm. Increased localized uptake is usually referred to as "hot" or hyperfunctioning nodules. Either "hot" or "cold" nodules may have normal global function studies. An example of the relationship between thyroid function and thyroid scin-

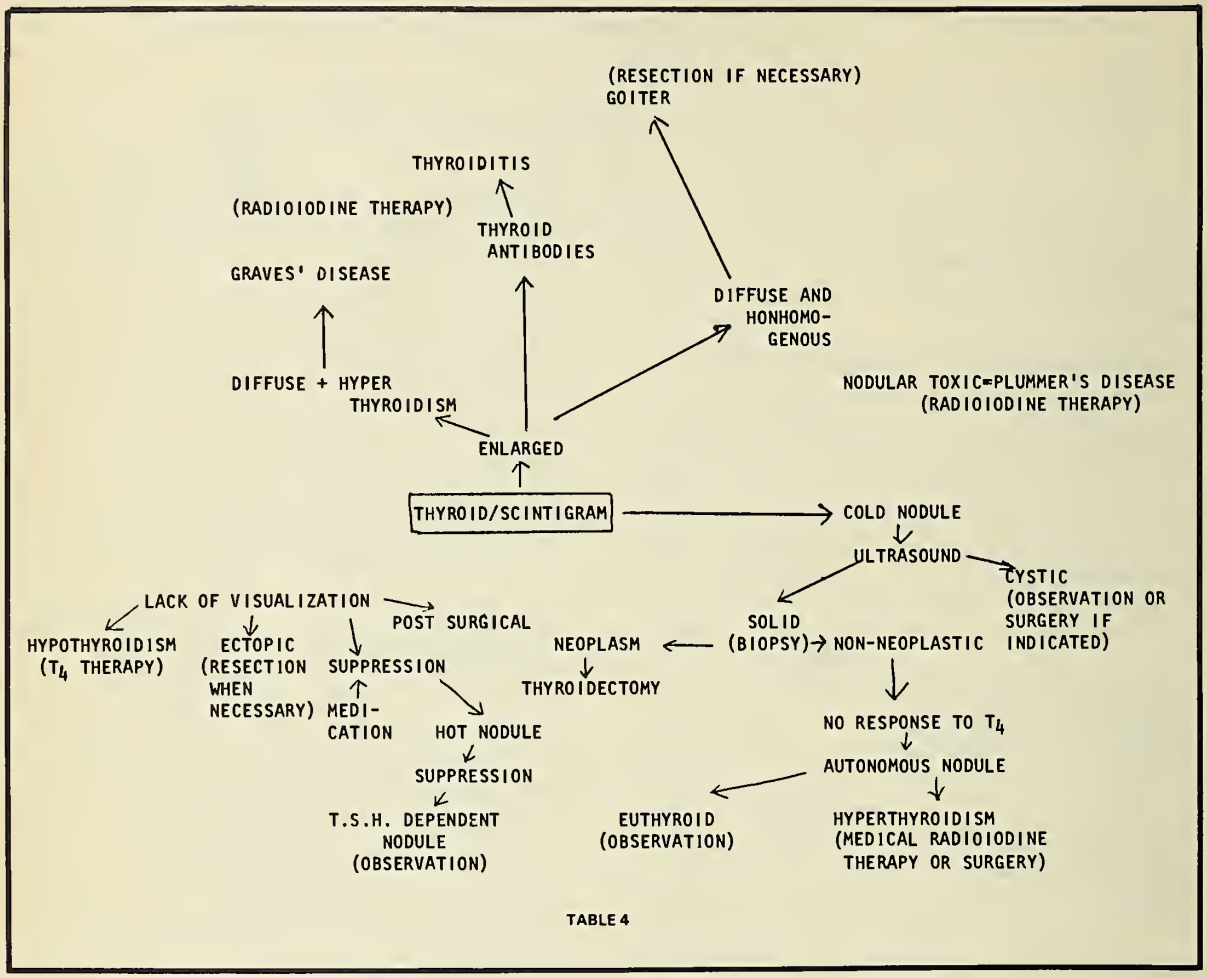


TABLE 4

tigraphy is demonstrated in Figure 1. A "cold" nodule, especially if it does not "light up" (function) after administration of TSH, is suspicious of neoplasm and indicates a need for thyroid biopsy or surgery. In cases with surgical confirmation of malignancy, postoperative search for metastases may be indicated. If functioning metastases are suspected, this is better accomplished after removal of the thyroid. Thyrotropin (TSH) is administered for 3-5 days and a whole body scan is performed after administration of 1-3 thyroid. Thyrotropin (TSH) is administered for 3-5 days and a whole body scan is performed after administration of 1-3 millicuries of 131_I.

Voice changes can result from compression by tumor or goiter. They can be accompanied by dysphagia or hoarseness. These can result from thyroid surgery, especially if there was a total thyroidectomy, with severance of a recurrent nerve. The main problem after successful surgery of the thyroid gland is to determine sufficiency of thyroid tissue for adequate function. Compensatory hyperplasia of thyroid remnants is a frequent finding after thyroidectomy. Its shape and function may be studied with thyroid scintigram, RAIU, T_3 resin uptake and T_4 serum levels. These studies should be performed after the patient has been off thyroid medication for 1-3 weeks.[5]

The presence of goiters is often diagnosed clinically. However, the internal structure might be studied with scintigraphy and ultrasound. The functional activity of the goiters should be studied because they can be associated with either hypothyroidism or hyperthyroidism.

Difficulty in swallowing can result from retrosternal goiter. The chest X-ray can show an infiltrate in the upper mediastinum. The clinical examination may demonstrate an enlarged thyroid. A scintigram of the thyroid and the upper third of the sternum may identify the existence of functional thyroid tissue in the area.



Figure 1
The thyroid is larger than normal, in the lower pole of the left lobe there is a prolongation with marked avidity for the radioiodine (hot nodule). The patient had all the clinical symptoms and laboratory findings of hyperthyroidism with a RAI of 82%. The patient required radioiodine therapy.

Pain and swelling of the thyroid gland can appear suddenly in pyogenic thyroiditis, (extremely rare) or more commonly in "subacute" thyroiditis usually associated with an upper respiratory infection (DeQuervain's disease). The inflammation destroys thyroid follicles, enlarging the gland generally and/or focally. The gland is tender at palpation. The global thyroid function can be normal, transiently increased or decreased. The 24-hour radioiodine uptake can be decreased and the scintigram reveals a non-homogeneous distribution of the radioactivity with occassional cold nodules in an enlarged gland. The differential diagnosis should be established from hemorrhage into pre-existing adenomatous thyroid, non functioning adenoma and from neoplasm, with which it is rarely associated.[6]

Chronic thyroiditis (Hashimoto's disease) is of slow evolution with gradual non-tender thyroid enlargement. It is difficult to differentiate from simple colloid goiter either clinically or scintigraphically. Hashimoto's disease is probably of autoimmune origin and is often accompanied by elevated titer of thyroid antibodies.

Some tests, such as RAIU, are now less used because of their interpretative complexity, due to influence by factors other than thyroid diseases or performance difficulties.[7] One is the basal metabolism rate. However, this test is the only direct measurement of the overall status of metabolic activity of the organism.

Serum cholesterol, lipoprotein electrophoresis and serum calcium will provide supportive, but non-specific diagnostic evidence when hyper or hypothyroidism are suspected. Elevated levels of calcitonin, either basally or after pentagastrin stimulation indicate medullary thyroid carcinoma. This test is particularly useful in identifying those relatives of known affected patients who may harbor the disease asymptomatically. Hematological serum levels of various enzyme values and sedimentation rate might also assist characterization of thyroidal disease. ◀

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Case Reports

Acute Cecitis

By Ivo Sklenar, M.D., Harry Kurz, M.D
And Mitchel P. Byrne, M.D./Evanston

An unusual inflammatory process in the right lower quadrant—cecitis—is described. Although not common, this challenging diagnostic and therapeutic entity will be seen on occasion by many physicians.

The course of a patient with documented primary necrotizing cecal inflammation is presented. Various etiologies, including pneumococcal, parasitic, fungal, and viral, are reviewed. The pathology and clinical presentations of phlegmonous cecitis are described. The alternatives in management, including drainage along, patching, or resection, as used in this case, are presented and a rationale for therapeutic decision making is outlined.

Until the middle of the nineteenth century all suppurative and inflammatory processes in the right lower abdominal quadrant were called typhlitis or perityphlitis. It was not until 1886 that Fitz clearly described the true pathology in these cases as due to appendiceal, not cecal, inflammation.[1] Afterward, the possibility of a primary inflammation of the cecum was denied until some rare descriptions of primary cecitis began to appear in the literature in the forties.[2] Until recent description of a pneumococcal cecitis in 1976, this subject earned little attention in the current American literature.[3,4] Our attention was drawn to this rare entity recently because of its occurence in a young, otherwise healthy, female.

Case Report

The patient was a 25-year-old white female who was in generally good health until two days prior to the admission. Two days before hospitalization she developed epigastric pain, initially diffuse, then localizing to the right lower quadrant. She didn't vomit and wasn't nauseated, but had diarrhea for 48 hours. She was taking tetracycline orally for one month because of acne problems.

On admission, her temperature was 100.4°. There was marked tenderness and guarding in the right lower quadrant. The remaining physical examination was unremarkable. The white count was 16,200 with 66% polymorphonuclears and 16% bands. The rest of the work-up was essentially normal.

Because of suspected acute appendicitis, the patient was explored via a McBurney incision. The operative findings demonstrated an acute necrotizing inflammation of the posterior part of the cecum and ascending colon (Figure 1). The appendix was intact. No foreign body was present. Purulent exudate was localized to the retrocecal area. A right hemicolectomy was performed. Primary anastomosis was

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Figure 1

carried out; two Penrose drains were left in place. The incision was closed routinely, and the skin and subcutaneous tissues were left open. The patient was treated with Keflin® and Cleocin® for nine days and recovered uneventfully. The secondary wound closure was carried out five days post-operatively.

The pathology report revealed dense inflammation and infiltration of the posterior wall of the cecum with polymorphonuclear leucocytes. The mucosa was intact, without inflammation. The appendix was normal.

Cultures from the purulent exudate showed growth of *Pseudonomas aeruginosa, Streptococcus fecalis, Streptococcus group D, Bacteroides fragilis, E. coli* and *Clostridium perfringens.*

Discussion

The etiology of non-specific cecitis is not well understood. Various etiologies, such as bacterial invasion of the submucosa from superficial mucosal abrasions due to hard fecal masses, foreign bodies, parasitic infection or secondary hematogenous infections, have all been described in the literature.[1,6] In addition, specific types of cecal inflammatory lesions are mentioned, such as tuberculosis, actinomycosis, blastomycosis, and amebiasis.[6] Other lesions with similar clinical findings may include solitary stercoral ulcers, segmental ulcerative colitis, terminal regional ileitis, carcinoma of the cecum with abscess formation and acute cecal diverticulitis.[1,5,6] The histology of non-specific cecitis is described as a cellulitis of the submocosa with infiltration of polymorphonuclear leucocytes and possible spread into the muscularis, subserosa and mucosa. *Streptococci, Staphylococci,* facultative anaerobic *Streptococcus* but also *E. coli* and *Pneumococci* have been isolated.[1,3,4,6] Deficient immune response is considered a predisposing factor. This has been described in chronic myelogenous leukemia, acute leukemia and reticuloendotheliosis. Localized nonsegmental gangrene of the cecum was also described as a complication of acute rheumatic fever in two Iranian children without any intraoperative findings of vascular impairment.[4]

Three pathologic types of phlegmonous cecitis can be distinguished: (a) circumscribed solitary; (b) circumscribed multiple and (c) diffuse.[1,5,8] The mucosa may or may not be involved. The appendix is normal except for mild inflammatory changes secondary to its neighboring location (*i.e.,* periappendicitis).

Three different clinical presentations are noted. One type is an acute form of disease which is often identical to the presentation of acute appendicitis. There is, however, a tendency for early development of a palpable mass in the right lower quadrant due to cecal infiltration. Thus, the presence of a right lower quadrant mass in a patient with a very short history might suggest this rare disease. The second type of clinical presentation is a chronic form, with a history of pain for months prior to surgery. The third type is a mild self-limited course; however, diagnosis of this form is rarely made because surgical exploration does not occur.

There are several therapeutic approaches, depending upon the clinical stage of the disease, which can only be evaluated intraoperatively. If the possibility of perforation seems extremely unlikely, then an omental patch can be sutured over the inflamed area and the wound closed. Drainage is often used, but some patients have recovered with patching and without drainage. The appendix has often been resected but is sometimes left intact. Recovery with subsequent antibiotic therapy has been reported with the above management.

It would seem, however, that if significant necrosis of the cecal wall is present, resection of the cecum and a portion of the ascending colon is the best management. An ileoascending colonic anastomosis, as in our case, can then be carried out with reasonable safety, thus avoiding an ileostomy. Obviously, a critically ill patient with necrosis of the cecum and extensive contamination should have resection with ileostomy or an exteriorization with no attempt at anastomosis.

Thus the exact operative management will be determined by the condition of the patient and the degree of inflammatory change in the cecum. The degree of necrotizing inflammation present in our case would support more aggressive surgical management than has been described in some previous reports. Removal of the phlegmon allows for rapid recovery and also allows for pathologic evaluation of the specimen to rule out any other unexpected lesion, such as carcinoma. ◀

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Case Reports

Due to Recurring Pulmonary Emboli

Failure to Wean From a Respirator

BY NICHOLAS M. DIFILIPPO, M.S., D.O., NORMA B. GOLDBERG, M.D.
AND JOHN T. SHARP, M.D./HINES

A 66-year-old male could not be weaned from a respirator post-surgically because of recurring pulmonary emboli. Failure of both medical and surgical management was demonstrated. Thromboembolism involving both main pulmonary arteries was verified at autopsy five days after insertion of an umbrella filter. Our review of the literature failed to reveal references to pulmonary embolism as a cause of failure to wean from mechanical ventilation.

There are numerous disease processes contributing to failure to wean from respirators. One always to be considered is recurring pulmonary emboli with infarction. Unfortunately, there appears to be a paucity of literature concerning this point. The following case history may be considered representative.

Case Report

A-66-year-old white male was transferred to our hospital because of inability to wean from a respirator. Review of the previous hospital records shows that the patient had been admitted one month earlier for advanced ischemia of both legs. On admission, the patient was noted to have advanced arteriosclerotic disease. An EKG done at that time showed a right bundle branch block, left anterior hemiblock and an old myocardial infarction. A translumber aortogram showed complete occlusion of the aorta at the renal arteries. The patient refused amputation of the lower extermities, and the aorta was explored two weeks after admission. A thromboendarterectomy was performed and aortic bifurcation graft inserted without difficulty.

The patient, however, had a stormy post-operative course, primarily because of respiratory problems secondary to secretions from the tracheobronchial tree, and could not be weaned from mechanical ventilation. He also developed arrhythmias consisting of atrial fibrillation and atrial flutter which responded to antiarrhythmic agents. On the seventh post-operative day, the patient eviscerated and was taken to surgery. Post-operative course was again complicated by respiratory failure with difficulty in weaning. At



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Figure 1



Figure 2



Figure 3

the time of transfer to our hospital, the patient was on digoxin 0.125mg IV daily, heparin 1500 units IV every four hours, aminophylline 250 mg IV every six hours, and sliding scale regular insulin.

On admission, the patient's temperature was 98.6°, blood pressure of 130/80, and pulse 84. He was alert and able to follow commands. A subclavian catheter was in place, as well as a Foley catheter and an endotracheal tube. Physical examination and EKG were unchanged from that previously described. The admission chest roentgenogram is shown in Figure 1. The white cell count was elevated to 14,000 and the serum creatinine was 2.3.

An elective tracheostomy was performed without complications. On the following day, the patient experienced pleuritic chest pain and a pleural friction rub was heard on the right side. This pain was accompanied by fever and the patient was started on IV cephalothin and continuous heparin infusion. On the following day, the patient became diaphoretic and a chest X-ray (Figure 2) showed densities in the right lung base. A perfusion lung scan (Figure 3) was consistent with pulmonary emboli to the right lower lobe, and the patient was believed to have pulmonary embolism with infarction. Three days after surgery, the patient experienced tonic-clonic seizure activity without loss of consciousness and was seen by a neurology consultant, who could find no neurologic deficit but could not exclude the possibility of cerebral emboli. On the same day, because subacute bacterial endocarditis was suspected, the patient had an echocardiogram, but no abnormality was detected. During the next few days, the patient continued to have spiking temperatures up to 104° with a white cell count of 14,000, and 80% segmented neutrophils, 11% band forms, 3% monocytes, 4% lymphocytes, and 2% metamyelocytes. The BUN was 57 six days after surgery and the hemoglobin was 9.9. The patient also experienced episodes of atrial fibrillation and flutter. A Swan-Ganz catheter was inserted. Pulmonary vascular pressures were as follows: right ventrical, 40/0; pulmonary artery (mean), 28; pulmonary wedge pressure, 6. Ten minutes later, the pulmonary artery mean pressure rose suddenly to 50 and the wedge pressure to 32. Eight days after surgery, a urine culture positive for enterococcus was obtained and the patient was started on penicillin and gentamicin.

Patient was taken to surgery for insertion of an umbrella filter. The course over the next few days consisted of respiratory distress, fever to 104°, and occasional hemoptysis. Chest X-ray showed a wedge-shaped density in the right lower lung field as well as pulmonary edema. A Swan-Ganz catheter was reinserted; right atrial pressure was four and a right ventricular pressure 44/4. Pulmonary artery pressure was 44/17, with a mean of 27. Pulmonary wedge pressure was eight. Four days after umbrella filter insertion, swelling of the right arm occurred with hypotension, blood pressure decreasing to 90/40. The swelling of the right arm decreased over the next few days with elevation of the arm; the hypotensive episode responded temporarily to administration of normal saline. Later, however, the patient became tachypneic and the wedge pressure rose to 15. Hypotension persisted along with increasing evidence of renal failure, possibly secondary to decreased perfusion. On 5-30-77, the patient became diaphoretic and had bradycardia. A cardiac arrest followed and CPR was unsuccessful.

Post-mortem examination showed recent bilateral pulmonary thromboembolism with recent infarction of left upper lobe and left lower lobe and an organizing infarction in the right lower lobe. There was also bilateral pulmonary edema with bilateral pleural effusion. Dissection of the pulmonary artery revealed presence of thromboembolism involving both main pulmonary arteries and their branches (Figure 4). The umbrella filter was located in the lower portion of the inferior vena cava and was found to



Figure 4

be filled with clotted blood. Heart examination showed an area of healed myocardial infarction on the posterior wall of the left ventrical. A probe patent foramen ovale was present. Adrenal cortical hyperplasia with recent infarction was also noted. Examination of the brain showed an organized infarct of the left cerebellum. The immediate cause of death was attributed to pulmonary infarction resulting from pulmonary thromboembolism.

Discussion

This patient demonstrates failure of both medical and surgical management of recurrent pulmonary emboli with infarction and resulting failure to wean. Prior to transfer and during the initial period of hospitalization at our institution, the patient was maintained with what has been described as "mini-dose" heparinization. However, once pulmonary embolism with infarction was strongly suspected, the patient was placed on continuous infusion of heparin. Despite adequate medical treatment, the patient continued to have recurring pulmonary embolism with inability to wean and an umbrella filter was inserted. The patient, however, still continued to experience pulmonary emboli, massive in nature as shown by subsequent autopsy. The umbrella filter was full of clots on autopsy, showing adequate function. According to Silver and Sabiston,[1] the rate of recurrent embolization in patients treated with "adequate" amounts of heparin varies from 0 to 18% with an average of about 5%. Prior to the work of Gurewich, *et al.*, [2] recurrence of pulmonary embolism after ligation of the inferior vena cava was assumed insignificant. Gurewich, *et al.*, however, using a technique of ligation (rather than caval interruption), showed the recurrence rate to be about 20%. They further point out that "there is an extraordinary reluctance to make a diagnosis of recurrent pulmonary embolism after ligation since it has been assumed to be improbable." Furthermore, although the authors concentrated primarily on the long-term protection of inferior vena caval ligation, they noticed evidence of pulmonary embolism occurring as recently as two days after ligation. Our review of the literature failed to reveal references to pulmonary embolism as a cause of failure to wean from a respirator, although, as exemplified in this case, this may be the immediate cause of death even after what is presently considered to be "adequate" medical and surgical management.

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Case Reports

Malignant Fibrous Histiocytoma Arising Ten Years After Irradiation Of A Histiocytic Lymphoma

By Wagih M. Shehata, M.D., F.F.R., James M. Hall, M.D.
and Olga J. Dobrogorski, M.D./Cincinnati

We are reporting a case of a malignant fibrous histiocytoma that originated in the local area ten years after curative radiotherapy of a histocytic lymphoma.

Sarcoma in a previously irradiated area is rather uncommon.[1,2] This usually occurs after a latent period, ranging from a few to 29 years after doses commonly above 3,000 rads and is especially seen in patients who receive more than one series of irradiation.[2,3] Cahan[4] proposed the following criteria by which radiation induced radiation sarcomas may be determined: (1) no microscopic or roentgenological evidence of the original malignancy in the area previously irradiated; (2) new sarcoma in the irradiation field; (3) long asymptomatic latent period and (4) histological proof of a new lesion. We believe the following case meets these criteria.

A 34-year-old white male presented at the Cleveland Clinic with a reticulum cell sarcoma of the mediastinum, presumably Stage I (after a mediastinoscopy). The original biopsy at that time was reviewed and thought compatible with diffuse histiocytic lymphoma. At that time the patient was treated by a Cobalt 60 beam utilizing two parallel opposing anterior/posterior fields, covering the mediastinum and the adjacent supraclavicular lymph nodes. He received 3,500 rads over a period of three and a half weeks (1,250 ret). The gross mediastinal adenopathy subsided on subsequent chest X-rays. Three months later the patient developed a cough. Chest X-ray revealed a recurrent mass in the mediastinum. The patient was seen at another institution. Five months after initial visit, he was treated by additional Cobalt 60 therapy (split course), utilizing again two parallel opposing anterior/posterior fields for a total of 3,200 rads, delivered in 16 treatments over a period of 32 days (1,023 ret). This was followed by complete disappearance of the mediastinal mass. No attempts were made to shield the spinal cord in either of the two radiation courses.

One year later, the patient was rehospitalized for progressive shortness of breath. A pericardial window was performed to relieve pericardial effusion, which was believed to be caused by irradiation pericarditis.

The patient did well without any evidence of his lymphoma for nearly eight years, when he noticed a bulky subcutaneous soft tissue mass in the right paraspinal area between the spine and the medial border of the right scapula. The patient was hospitalized because of progressive mass enlargement, which had reached 15x10x6cms. The tumor mass was soft to firm in consistency, rather fixed, occupying the subcutaneous tissues with no significant skin ulcerations. The tumor arose from an area of dense skin and subcutaneous fibrosis with telangectasia and pigmentation believed to be related to previous irradiation. Similar skin changes could be seen delineat-

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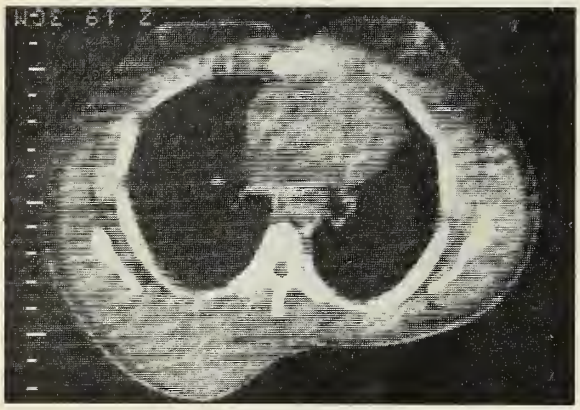


Figure 1
Computerized axial tomograms of the chest showing a right paraspinal mass.

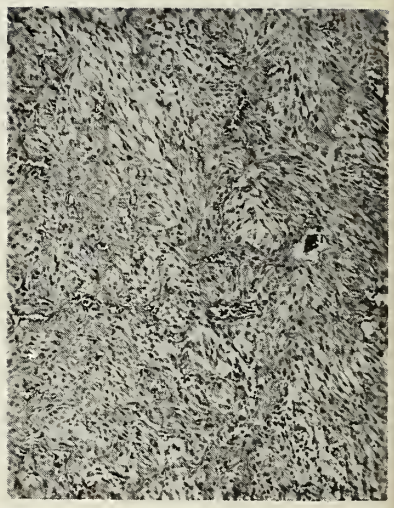


Figure 2
Histological picture of the reported case.

ing most of the treatment port. Workup, including chest X-ray, liver and bone scans and CAT scan of the abdomen, was unremarkable. CAT scan of the chest (Figure 1) revealed a posteriorly located bulky mass. This mass was excised with probable residual microscopic disease left around the adjacent vertebral foramina. The histological examination revealed pleomorphic sarcoma consisting of spindle shaped fibroblastic cells, arranged in a storiform pattern. This was associated with more plump histiocytic-appearing elements, some of which showed bizarre hyperchromic nuclei (Figure 2). The tumor was interpreted as malignant fibrous histiocytoma. This was supported by a report of the Armed Forces Institute of Pathology. We elected not to treat the patient by further irradiation rather than risk spinal cord complications. Instead, he received six courses of Methotrexate® at three week intervals (total of 10,500 mgs.) with Citrovorum® factor rescue. The patient subsequently developed local recurrences in spite of the chemotherapy. The patient pursued a downhill course with jaundice from liver metastases. He expired six months after hospital admission.

Discussion

The oncogenic effect of ionizing irradiation is well known.[1] It occurs after a latent period, when the primary cancer is usually cured. Sarcomatous lesions are the most commonly seen tumors in the irradiated field. Malignant fibrous histiocytoma, a recently recognized tumor,[5] is rarely seen as a late effect of irradiation. Gonzalez[5] reported a similar case eleven years after receiving 3,600 rads to a chromophobe adenoma of the pituitary gland. Jochimsen[6] described an undifferentiated pleomorphic sarcoma in a patient seven years after treating stage II-A Hodgkins' disease by 3,550 rads of Cobalt 60 to the mantle area.

Our case represents a patient who was treated by a relatively high dose of irradiation (two series, separated by about six months). The patient had developed irradiation pericarditis and fibrosis in the subcutaneous area of the treatment port as the result of the therapy. The sarcoma had developed in an area which was heavily irradiated at a time when he was considered free of his original lymphoma. Surprisingly enough, the patient did not develop any irradiation myelitis, despite large doses to the spinal cord. The disease course after developing sarcoma was rather short, resulting in local recurrence and distant metastases. The fact that he had initial lymphoma could indicate immune deficiency state as an underlying cause. Waga[3] also discussed this possibility in his report of meningioma developing after cranial irradiation. In another report,[7] sarcoma arising in the irradiated jaw bones seemed to be related to a pre-existing non-malignant bone lesion in the jaw.

As radiotherapy is being utilized more widely for curative intent in various malignant conditions, one should be more careful in delivering optimal doses to avoid future morbidity. A careful follow-up to detect early second malignancy after previous irradiation conceivably could save some of these patients. ◀

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Membership Forum

Membership Forum is intended to serve as a communicative tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. The Editors cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

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25 Years In The Trenches or How Things Look From Down Here

By P.F.C.* Jannings

It seems to me that the delivery of medical care follows the "trickle-down" and "flaking off" process. By this I mean that procedures, once the province of subspecialists, move down to the specialists, then down to the primary care physicians, then to allied health workers, then to the patients (for example, "allergy shots"). Spearheading the attack on disease are the basic scientists, medical researchers, and a few practicing physicians. The army (of medical technicians—specialists—subspecialists—medical educators) follow and mop-up pockets of resistance. The army of occupation (family doc's, GPs, osteopaths, internists, pediatricians, and other primary care professionals) brings up the rear and maintains the "peace".

Each primary "pacification" physician heads a "team" responsible for 1,500-6,000 natives (locals). This team leader has a first sergeant (NP, PA, Medical Assistant, RN, LPN, Girl Friday, or ?) who runs the platoon under the boss's supervision. There may also be a weapon specialist (lab and/or X-ray tech), a gunnery sergeant (RN), communications technicians (receptionist and/or medical secretary), and records specialist (bookkeeper/accountant).

Each "pacification" team cares for, counsels, and educates the locals in its medical trade area. As medical science advances, the trickling-down and flaking-off occurs continuously. The spearhead continuously advances to new ground—leaving new pockets of resistance to be mopped-up by subspecialists who move to new ground adding new procedures, drugs, and equipment to the primary care professional's armarmentarium. As experience is developed, procedures and techniques once done only by licensed physicians are taught to team members, who in turn teach them to the locals, who become more sophisticated and skilled at self-care and health maintenance.

Some locals now monitor their own and their spouse's blood pressure, give their own allergy shots, read the PPI's (patient package inserts), serve on HSA's (Health Systems Agencies), and carry out IPPB and Physio-therapy at home, monitor head injury cases at home, provide support systems for alcoholics (A.A.), mastectomies (Reach to Recovery), the ostomies, the laryngectomies, the amputees, the obese, the recovered psychotic, the pregnant (LaMaze, LaLeche,) etc.

It is a function of the general primary care physician to accept new responsibilities, for example regulation of Lithium dosage in bi-polar disease, and delegate old ones, such as personal counseling, to mental health technicians. It is the responsibility of the general primary care physician (wherever located) to assess his local medical community's capabilities and adjust what he does and what his team does accordingly.

The suburban general primary care physician may not choose or be permitted to take and read chest, skull, spine, gall bladder, rib, and extremity X-rays. He may not choose or be permitted to do vaginal deliveries or Cesarean sections, gall bladders, appendices, herniae or varicose veins. He may not choose or be permitted to pin hips, remove bunions, and reduce and cast extremity fractures. He consequently may not choose to delegate patient assessment responsibilities to PAs, delegate treatment plans for obesity and hypertension to RNs, delegate follow-up responsibilities for diabetes and anti-coagulants to lab techs, or delegate patient education and counselling to other allied health personnel.

However, the rural or inner-city primary care physician may find it expedient to do just these very things, and the statutory regulation of certified and licensed personnel must be flexible enough to permit these variations in practice, but restrictive enough to prevent abuse and poor standards of care.

This "downward trickling" or "flaking off" is a process essential to optimum utilization of a general primary care physician's skills in most rural areas, and especially in under-served areas. Specialty societies, hospital credentials committees, and state and national medical societies should recognize the different patient mixes, patient needs, physician skills, and availability of medical and surgical subspecialty personnel in the various medical service areas of the state.

It should be recognized that rules and regulations restricting "downward trickling" and "flaking off" will deter delivery of medical care in rural and especially underserved areas. ◀

Charles J. Jannings, M.D./Fairfield

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Viewbox

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DIAGNOSIS: PULMONARY COCCIDIOIDOMYCOSIS

The patient has a thin walled cavity in the right lower lobe. In adults, the differential diagnosis of a single thin-walled intraparenchymal cavity is extensive. The following table lists causes of single, thin walled (less than 2mm) lesions of the lung in an adult.

Airway Disease—Bullous emphysema.

Infectious Disease—Atypical myocobacterial infection, fungal infection (coccidioidomycosis, cryptococcosis, sporotrichosis, geotrichosis, blastomycosis), staphylococcal or gram negative pneumonia causing pneumatoceles, parasitic diseases (echinococcosis).

Embolic Disease—Necrotic pulmonary embolus, septic embolus.

Neoplastic Disease—Hematogenous metastasis, Hodgkins or non-Hodgkins lymphoma.

Autoimmune Disease—Wegener's granulomatosis, polyarteritis nodosa.

Trauma—Hydrocarbon ingestion with pneumatocele formation, traumatic lung cysts (pulmonary laceration).[1,2]

In the evaluation of this roentgen lesion the history is essential. The patient's recent trip to Arizona with a subsequent flu-like illness makes the diagnosis of pulmonary coccidioidomycosis most likely. In this patient sputum cultures grew *C. immitis.*

Coccidioidomycosis is a disease caused by inhalation of arthrospores of the fungus *Coccidioides imitis.* The septated mycelial form grows in soil and produce chains of arthrospores. These hardy, small spores are viable for years and when inhaled become the infectious form of the organism. Once inhaled the spores swell into spherules which cleave to produce endospores. The endospores again mature into spherules and perpetuate the process. Only the mycelial-arthrospore phase is infective; thus, man to man spread does not occur.[3]

C. immitis is endemic to areas in the southwestern USA, northern Mexico, Guatemala, Paraguay, Venezuela, Columbia and Argentina (where the disease was first recognized). These areas correspond to the Lower Sonoran Life Zone

(Continued on page 116)

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Viewbox

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with semi-arid conditions and short, intense rainy seasons. Because the organism inhabits the soil, infection is intimately related to host-soil contact. Although any man-soil contact can cause infection, contact is highest during dry, windy seasons especially in construction areas and anthropologic/archeologic exploration sites.[3] Interestingly, once an area is irrigated or is used agriculturally, the fungus is virtually eliminated.[4] Both humans as well as animals are affected; indeed, it is the disease most frequently encountered in California slaughterhouses.[5]

Of those affected, at least 60% are asymptomatic, with a positive skin test as the only evidence of disease.[3] The remaining 40% become symptomatic 1-4 weeks after exposure. Symptoms range from mild, influenzal complaints to frank pneumonia. Although many classifications of the disease exist, Winn's clinical-roentgen concept appears to be the most useful.[6] The three main forms are primary pulmonary coccidioidomycosis, residual pulmonary disease, and disseminated coccidioidomycosis.

Primary pulmonary coccidioidomycosis is a self-limited disease consisting of cough, fever, pleuritic chest pain and headache.[3] Approximately 10% of patients will experience a fine, diffuse, macular, erythematous rash of the trunk and extremities during the first few days of the illness. "Valley fever" is a symptom complex of erythema nodosum, erythema multiforme, arthralgias, and conjunctivitis. Erythema nodosum occurs in approximately 15% and is more common in caucasian females. It occurs about the time the skin test becomes positive. Roentgenographically, the disease is characterized by soft, hazy infiltrates, single or multiple, segmental or lobar. Pleural involvement with effusion is common and 20% have hilar adenopathy. Resolution occurs within several weeks. Eosinophilia commonly accompanies the illness.

Chronic residual pulmonary disease occurs when the symptoms or roentgen pattern persists past 6-8 weeks.[3] The spectrum ranges from persistent or progressive pneumonia to nodules and cavities. All of these are uncommon, affecting patients less than 5% of the time. Nodules tend to occur in the mid lung near the hilum, most are single and measure 1-4 cm, and are thought to represent undrained or poorly draining lung abscesses.[3] Cavities may present within ten days but typically occur later. Although hemoptysis is uncommon in all other forms of the disease, it occurs in 70% of patients with cavities.[3] Early in their course cavities are thick and shaggy walled. With progression, the wall shells out producing a

thin walled cavity. 90% are single, 70% are found in the upper lung fields, and most measure from 2-4 cm in diameter.[7] Cavities commonly fluctuate in size and once found may persist for longer than 2 years.[8] For the most part they are benign.[7,8] Complications include pyogenic infection, fungus ball formation, pyopneumothorax due to bronchopleural fistulas and pulmonary hemorrhage.[3,7]

Dissemination is favored in blacks and Fillipinos, during pregnancy, in the immunodepressed, and in the very young and old.[3] Fortunately, less than 1% progress to this state. Although all organ systems are affected, the most common sites are skin, bone, lymph node, and meninges.[3] Dissemination in the lungs is characterized by a miliary pattern.

The diagnosis of coccidioidomycosis is made on historical data, spherule identification in biopsy specimens, cultures, skin tests and serology. The coccidioidin skin test becomes positive 3 days to 3 weeks after onset of symptoms and indicates past or present infection. A negative skin test does not exclude infection as it is often negative in disseminated disease. It is quite specific, though it rarely is positive in patients with active Histoplasmosis.[3] Precipitating antibodies (IGM) are produced early but are transient. Complement fixating antibodies (IgG) appear later and may persist. A rising titer may portend dissemination.[3]

The primary form of coccidioidomycosis is treated symptomatically while the disseminated and severe pulmonary forms require amphotericin B. The role of surgery is controversial and is limited to patients with: a rapidly expanding cavity with risk of rupture, bronchopleural fistulas, symptomatic mycetoma and serious or persistent hemoptysis.[3] A solitary nodule may be removed for diagnostic purposes. ◀

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Pulse of the ISMS Auxiliary

Who—If Not You?

By Mrs Harlan Failor, President, ISMSA

The subject is "Legislation"—the very reason that many county auxiliaries came into being, and certainly the stimulus for much of the close cooperation we have seen recently between the Society and the Auxiliary.

The Medical Auxiliary has always been aware of its power potential in this field and from the beginning has stated that one of its primary objectives is "to improve health care and medical practice by impacting legislation." For years we talked the good fight, but now we are putting our words into writing, our time into Key contacts, and our money into IMPAC. Sometime during the last decade we came to the realization that not to participate in the formulation of government policy was to have no voice in decisions which would affect the health of our communities, the practice of our husbands, and the well-being of our families.

Someone has said that the Medical Auxiliary has a grassroots organization that is a politician's dream. We can throw our influence behind any cause and make a difference. If, however, we are to be spokeswomen for medicine, we owe it to our spouses and the profession to be knowledgeable advocates.

Our legislative education comes from a variety of experiences. An impressive number of Auxilians attended the 1980 ISMS Legislative Conference in Springfield last May; the Kankakee County Auxiliary brought a bus full of interested members. In October, at the Auxiliary's Fall Conference in Decatur, Auxiliary members from every part of Illinois listened intently as Mr. Donald Udstuen, Director of the ISMS Governmental Affairs Division, gave them a look at "Power in Politics" and emphasized the role a physician's spouse can play in the legislative process; the talk was informative *and* entertaining. As early as April, Mrs. Alan Taylor, ISMSA Legislation Chairman, set before the Auxiliary the goal of getting every member of the doctor's family registered for the November election; the campaign was a success.



Mrs. Alan Taylor, ISMSA Legislation Chairman and Mr. Donald Udstuen, Director, ISMS Governmental Affairs Division, at 1980 Fall Conference.

Now a new legislative program is being offered to the ISMS Auxiliary by Mrs. Taylor and Mr. Robert Burger, Director of the ISMS Division of Field Services. The proposal suggests that Auxiliary members monitor Health System Agency (HSA) Board and Committee meetings and bring HSA documents and reports to the attention of the medical community. Members would involve themselves in the planning process, as well, by seeking appointment to an Area council or task force—no small commitment. Interested Auxilians will be oriented by the ISMS Field Service staff and will work closely with their local medical Society. If there was ever a call to partnership, it is the challenge of these new regulations by government.

Participation is the name of the game, and any number can play (the more the healthier). With National Health Insurance no longer the threat it was, the physician and his family may be tempted to sit on the sidelines or desert the field entirely, leaving the lobbyists in Springfield and Washington to win the contest and report the score. But the season could be a losing one for medicine, and if so, who would be to blame?

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Doctor's News

NOT GUILTY IN CHIROPRACTIC SUIT—After some seven weeks at trial, the jury returned a verdict of "Not Guilty," on all counts, in the case of *Wilk, et. al.,* v. *American Medical Association, et. al.* Named as one of the defendants in this action was the Illinois State Medical Society. Originally, the suit was brought against twelve professional associations and four individuals. Two of the defendant associations had previously settled. The suit was based on the Sherman Antitrust Act and alleged that the defendants had engaged in a combination and conspiracy in restraint of trade. The decision will be appealed.

PHYSICIANS IN THE NEWS—**Alfred J. Kiessel, M.D.,** Decatur, has been reappointed to the Illinois Clinical Laboratories and Blood Bank Advisory Board. Dr. Kiessel, a pathologist, is a member of the ISMS Board of Trustees, representing the Seventh District . . . **Harold N. Walgren, M.D., J.D.,** has been installed as president of the DuPage County Medical Society. Dr. Walgren, a radiologist, resides in Hinsdale.

The 1980 Esther Langer Award was recently given to **Paul Heller, M.D.,** Chicago, for research in multiple myeloma and red blood cell production. Dr. Heller is a professor of medicine at the UI College of Medicine . . . Newly named president of the American Cancer Society is **Edward F. Scanlon, M.D.,** chairman of the department of surgery at Evanston Hospital.

Tolbert F. Hill, M.D., celebrated his 107th birthday last month. Dr. Hill, who is believed to be the oldest living Illinois physician, is a member of the Sangamon County Medical Society. He is the second of four generations of physicians in the Hill family, and joined the medical society in 1920. Dr. Hill graduated from Rush Medical College in 1896 and opened his Athens, Illinois office in 1898. In 1978, at a meeting of the ISMS Fifty Year Club, Dr. Hill received a plaque and pin commemorating 80 years of medical practice.

EMERGENCY ROOM MEDICINE will provide the focus for a morning seminar on Saturday, March 21, at the Chicago Conrad Hilton. Sponsored by the ISMS Resident Physician Section, the program is a part of the Chicago Medical Society Midwest Clinical Conference. No admission fee is required for the seminar, which will include speakers from several Chicago area medical schools who specialize in pediatrics, orthopaedics, OBGYN and Cardiology. (Further information about the Midwest Clinical Conference is available through the Chicago Medical Society (312) 670-2550.)

HEALTH CARE IN THE ELDERLY will be the subject of a fourth annual conference sponsored by the University of Iowa departments of family practice and internal medicine and the Iowa Gerontology Project. The two day meeting on March 19 and 20 is accredited for 15½ hours of AMA Category 1 credit. Further information may be obtained through Ian M. Smith, M.D., Department of Internal Medicine, University of Iowa Hospitals, Iowa City, Iowa 52242; (319-356-2727).

THE ISMS BOARD OF TRUSTEES encourages physician participation in an Illinois Cancer Council survey to determine how they feel about the benefits of tests and examinations aimed at early detection and prevention of cancer. The survey, to be conducted in March, is the final phase of the study of cancer information needs in Illinois. ISMS believes the data obtained will be a significant source of information to everyone concerned with the problems of early detection and prevention of cancer.

IMJ Attention

ILLINOIS HOUSE ELECTS NEW LEADERSHIP—The Illinois House of Representatives met January 14 to elect their new leadership. Rep. George Ryan (R) of Kankakee was elected Speaker of the House. Rep. Ryan, who has served in the Illinois House since 1972, is a pharmacist.

The House, now composed of 91 Republican representatives and 86 Democrats, chose Rep. Art Telcser (R), Chicago, also a pharmacist, as majority leader. The balance of Republican House leadership is as follows: Representatives Pete Peters, Chicago, Celeste Stiehl, Belleville, Phillip Collins, Chicago and Elmer Conti, Elmwood Park, assistant majority leaders; Representatives Lee Daniels, Elmhurst and Ben Polk, Moline, majority whips.

Democratic leadership in the House chose Rep. Michael Madigan, Chicago, as minority leader. The minority team will include Representatives Ted Lechowicz, Chicago, Zeke Giorgi, Rockford, James McPike, Alton, Mike McClain, Quincy and Eugenia Chapman, Arlington Heights. One minority leadership post remains to be filled.

ILLINOIS SENATE VOTE STIRS DISSENT—Through an unusual chain of events, State Senator David Shapiro, DDS, (R), Amboy, was elected President of the Illinois Senate.

The 1980 elections gave the Democrats a 30/29 edge in that body, but their January 14 leadership vote found that past Senate President Phillip Rock (D), Oak Park, held only 20 of the 30 Democratic votes needed to re-elect. Due to dissension on the Democratic side, they reconvened January 15 for a second roll call.

The Governor acts as chairman of the Senate during interim leadership periods, and Governor Thompson ruled on the 15th that the Senate President would be that candidate who held the most votes of those Senators present. (The Democrats hold a majority by only one vote in the Senate, and two of their number were not present. The absence of Sen. Harold Washington, who has been elected to Congress and Sen. Charles Chew, who was in the hospital, reduced the remaining Democrats to 28.

As the Democrats could not garner the 30 votes needed to overrule the chairman, they walked out in protest. The roll was called and 29 present Republicans voted for Sen. Shapiro, who was sworn in as President.

The Democratic Senators, led by Sen. Rock, have challenged the ruling in court, which could be time consuming. Delay in active work of the Illinois General Assembly can be expected.

A Democratic majority Senate governed by a Republican President can be expected to produce a number of anomalies. The most significant, however, is that if the ruling stands, Illinois Republicans will control the state administration and both legislative houses. The 1980 Census requires that Illinois legislative districts be redrawn during this session, and the successful cutback amendment reducing the size of the General Assembly will take effect as well. A single party controlling all three major bodies during redistricting can gain extraordinary control — and hold that control until the next national Census.

MORE THAN A DOZEN laws affecting health issues were passed by the 96th Congress, according to the AMA *Legislative Roundup.* AMA highlights some of these as follows:

The major Medicare/Medicaid legislation of this Session was the *Omnibus Reconciliation Act of 1980,* which includes 58 reimbursement-related provisions. The *Mental Health Systems Act* replaces the Community Mental Health Centers Act, defining federal programs to assist local mental health services. The law gives individual states greater input in program funding and, for the

first time, requires that community mental health centers have a physician in charge of clinical care services. *The Privacy Protection Act of 1980* protects the records of members of the news media from unnecessary search and seizure, and requires that the Attorney General must publish guidelines for record protection within federal agencies.

The *Health Programs Extension Act of 1980* gives states additional time to bring their health planning laws into conformance with federal requirements, exempts major medical equipment used solely for research from certificate-of-need review, liberalizes the National Health Service Corps private practice option, and extends or expands a number of standing programs.

Two Illinois legislators have assumed national leadership positions: Rep. Dan Rostenkowski (D), Chicago, will chair the House Ways and Means Committee. Robert Michel (R), Peoria, is the new House minority leader.

MEMBERSHIP RECRUITMENT EFFORT LAUNCHED—ISMS has initiated a major membership recruitment effort, in conjunction with the AMA and county societies. Each county society has received a list of names of non-member physicians in their area, and each of those non-member physicians has received a direct mailing with a membership benefits brochure and general information. It is hoped that individual members will support this effort by communicating with their colleagues.

CHILD CUSTODY PROJECT ANNOUNCED—The Isaac Ray Center, Section on Psychiatry and the Law, Department of Psychiatry, Rush-Presbyterian-St. Luke's Medical Center, has initiated a system to assist judicial determinations of custody, visitation and other issues pertinent to divorce. Staffed by child psychiatrists from throughout the Chicago area, each board certified in general psychiatry and conversant in medical-legal areas, the Child Custody Project is intended to provide competent assessments of families in conflict and serve the best interests of children in custody determinations. The Project functions on a fee-for-service basis. Further information may be obtained by writing Barbara A. Weiner, J.D., at the Center, 1720 W. Polk St., Chicago 60612; (312) 942-4462.

Librium® 5mg, 10mg, 25mg capsules
chlordiazepoxide HCl/Roche

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral–Adults:* Mild and moderate anxiety and tension, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d. Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Blue Shield®

REPORT FOR *Illinois Physicians*

COORDINATED HOME CARE DIRECT ADMISSION PROGRAM IS REACTIVATED

The pilot project for direct admission to specialized care facilities, started more than a year ago, is being reinstated for active employees of the Chicago Board of Education.

Under the program, the Chicago-based Blue Cross and Blue Shield Plan will pay for medically necessary care in an approved, participating Skilled Nursing Facility (SNF) or Coordinated Home Care (CHC) program without the member first having to be a hospital in-patient.

The direct admission program also is being made available to other Blue Cross and Blue Shield groups.

The current pilot project which started this month is scheduled to run through February, 1982.

Despite the waiver of the current requirement of a qualifying hospital stay prior to a SNF or CHC admission, the attending physician must certify that skilled care is required and that the patient can be cared for in one of these types of programs.

As under the regular SNF and CHC programs, covered benefits remain the same. Attending physician visits to the SNF or CHC are covered services and are counted for reimbursement the same as if the patient was in the hospital.

Billing procedures for physician services remain the same. Questions regarding billings of office visits, visits to the home or SNF should be directed to Bill Livingston, Professional Relations Department, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois, 60601, (312) 661-4488.

If you have a patient whom you may be thinking of admitting to an acute care hospital, and whose needs could be met in an SNF or CHC program, contact Mr. Livingston for a list of approved, participating facilities.

SPRING SERIES OF WORKSHOPS SCHEDULED

The Chicago-based Blue Cross and Blue Shield Plan's Spring workshop series for medical assistants in downstate Illinois cities will begin in Marion on April 1 and continue through May 21.

The workshops are intended to inform medical assistants in Plan administrative, claims and payment procedures and advise them of changes in Blue Shield benefits and contracts.

Letters of invitation are being sent to physician's offices with the reservation forms. For additional information, please write Mr. Bill Livingston, Professional Relations Department, Blue Cross and Blue Shield Plan, 233 North Michigan Avenue, Chicago, Illinois, 60601, or call him at (312) 661-4488.

The following workshops are scheduled:

Wednesday	April 1	Holiday Inn	Marion
Thursday	April 2	Best Western	Mt. Vernon
Wednesday	April 8	Holiday Inn	Effingham (a.m. only)
Wednesday	April 15	Augustine	Belleville
Thursday	April 16	Ramada Inn	Alton (a.m. only)

Wednesday	Aprill 22	Holiday Inn	Bloomington
Thursday	April 23	Ramada Inn	Peoria
Wednesday	April 29	Ramada Inn	Quincy
Thursday	April 30	Sheraton Inn	Springfield
Wednesday	May 6	Holiday Inn	Decatur
Wednesday	May 13	Ramada Inn	Rockford
Wednesday	May 13	Holiday Inn (Bradley)	Kankakee (a.m. only)
Thursday	May 14	Holiday Inn on Neil Street	Champaign
Wednesday	May 20	Holiday Inn	Moline
Thursday	May 21	Sheraton Inn	Galesburg (a.m. only)
Thursday	May 21	Ramada Inn	Ottawa (a.m. only)

LIBBY, OWENS, FORD UPGRADES HEALTH BENEFITS

Libby, Owens, Ford's employee health benefit program handled by the Chicago-based Blue Cross and Blue Shield Plan recently was upgraded.

Following is a breakdown of some of the more important changes in the program:

- The 90-day interval between date of discharge and date of the next admission for the same or related conditions has been reduced to 60 days.
- Hospital confinement for a TB condition has been increased from 30 to 45 days.
- Residential and out-patient substance abuse benefits provided for detoxification and rehabilitation of alcohol and drug abusers in approved free standing or hospital affiliated facilities are limited to 35 visits per year - 140 visits lifetime maximum.
- Prosthetic devices: In addition to internal devices, benefits will be extended to provide external prosthesis and orthotic appliances covered under Medicare as of October 1, 1979. This includes replacement, repair fitting and adjustments *when prescribed by a licensed physician.*
- Durable medical equipment benefits will be provided for the purchase, rental and repair of equipment covered under Medicare as of October 1, 1979, *when prescribed by a licensed physician* and necessary for the treatment of an illness or injury, or to improve functioning of a malformed body member.
- Out-patient physical therapy treatments are a covered benefit in approved facilities for up to 60 treatments per condition only if supervised by a registered or licensed physical therapist *when prescribed by a licensed physician.* The benefit period is renewable each calendar year; immediately following surgery related to the condition for which therapy was originally provided or following a distinct aggravation of the condition for which therapy was rendered.
- Chemotherapy benefits are provided for treatment of parenteral, continuous or intermittent infusion, perfusion and intra-cavitary therapy as an in-patient, in the out-patient department of a hospital, physician's office or home. Also included are three follow-up visits to a physician (the initial office visit charge is not covered) if performed within 21 days following the last day of eligible chemotherapy administration.
- Out-patient psychiatric benefits provided for psychiatric day care in a participating hospital will be charged against the 45-day in-patient nervous and mental maximum benefit period at a rate of two partial days for each nervous and mental day available. Out-patient benefits are subject to a combined Blue Cross and Blue Shield maximum of $1,000 per member per calendar year.
- Coordinated Home Care benefits will be provided to members *referred by a physician* on a direct admission basis. They need not be confined to a hospital or convalescent and long-term illness facility immediately prior to being admitted to the home care program.
- Routine pap smear: Blue Shield benefits will be provided for the laboratory and pathological examination for one annual Papanicolau smear per member.
- Computer transaxial tomography (CAT SCAN) benefits will be provided for diagnostic examinations of the brain and certain parts of the body as approved by Medicare and on equipment approved by a recognized area health planning agency or comparable approval organization.

(This report is a service to the physicians of Illinois)

IMJ

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for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

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**ase consult complete prescribing Informa-
, a summary of which follows:**

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

traindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction, hypersitivity to chlordiazepoxide HCl and/or nium Bromide.

nings: Caution patients about possible combined effects with alcohol and other CNS ressants, and against hazardous occupations uiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended es, but use caution in administering Librium® ordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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President's Page



An Idea for the 80's
Competition

The priorities of the new administration have not been announced but the predictions are: less money for new health programs; a slowing of authorized spending; and the expectation that doctors, hospitals, HMOs and insurers will get into the market place and—through competition—try to take control of the field.

The argument for competition goes back to the old Adam Smith concept that, because of self interest, people making diverse decisions will solve societal problems more efficiently than government controls and cut costs. Included in the concept is the notion that marketplace forces will work best when people have multiple options and no "perverse" incentives.

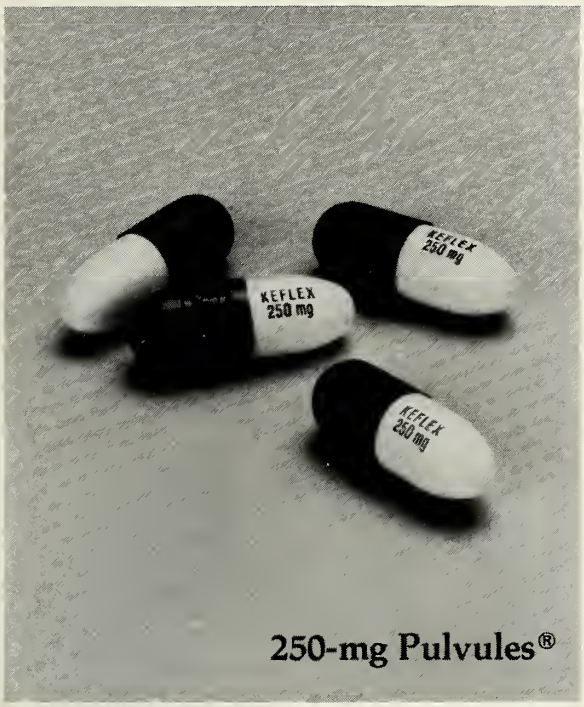
In 1977 the Carter administration asked Alain Enthoven, Ph.D., Stanford University, to develop a proposal for universal health insurance. His proposal was built upon a type of free-market competition among the providers of health care. Elements of this proposal have survived the change in administration. Last year, "competition" proposals included Sen. Durenberger's Health Incentives Reform Act and Congressman Gephardt's National Health Care Reform Act. Incoming HHS Sec. Schweiker sponsored a competition bill and can be expected to support a competitive approach in his new post.

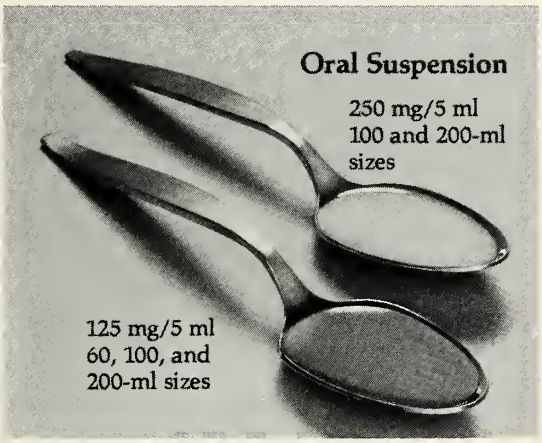
Competition and doctors are not strangers. I predict better service for our patients. ◀

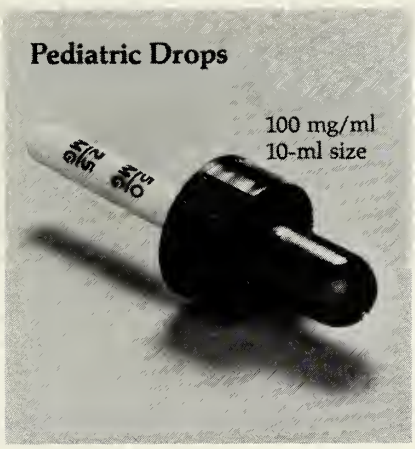
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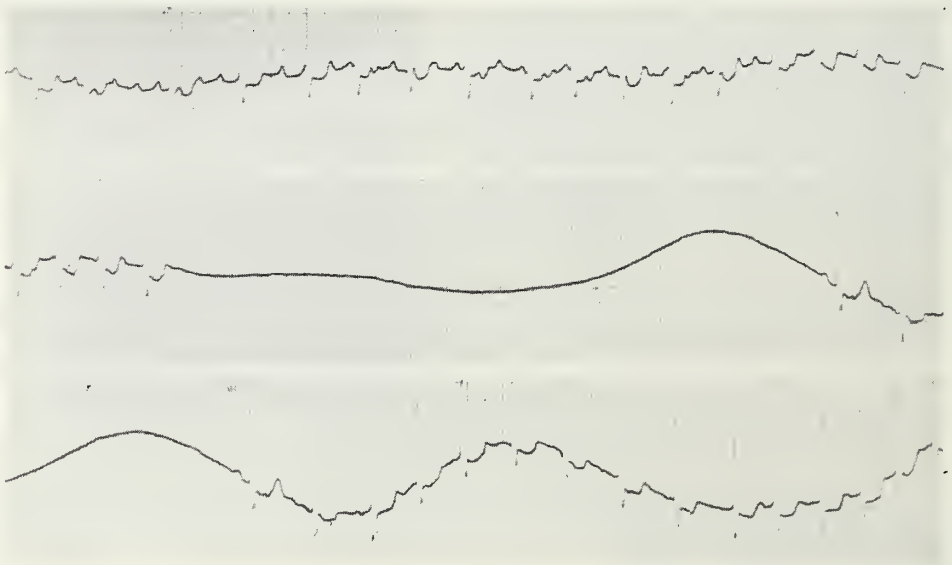
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EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., Dovid J. Hale, M.D., Potrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., ond Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Deportment of Medicine, Loyola University Stritch School of Medicine

This patient is a sixty-four year old man who was in good health until a year ago. At that time, he developed severe retrosternal burning pain and dyspnea. He was hospitalized and a myocardial infarction was ruled out. Despite anti-anginal medication, he continued to have exertionally induced retrosternal burning. He was scheduled for a coronary angiogram because the angina was limiting his ability to work. Two days before admission for the angiogram, he complained of a brief episode of transient blindness in his right eye. When questioned about this, he admitted to other milder episodes of blurred vision involving both eyes. None of these episodes ever lasted more than a few minutes and all cleared spontaneously. A coronary angiogram demonstrated severe coronary artery disease. An aortic arch and bilateral carotid angiogram was normal. A twenty-four hour Holter monitor (ambulatory ECG) was ordered. In the section shown, the patient experienced transient blurring of vision.



Questions:

1. **The ECG rhythm strip is compatible with:**
 A. Paroxysmal atrial flutter-fibrillation.
 B. Asystole preceding a sinus beat.
 C. The bradycardia-tachycardia syndrome.
 D. The sick sinus syndrome.
 E. All of the above.

2. **Treatment for this arrhythmia problem could include:**
 A. Digoxin on a long term basis.
 B. A demand pacemaker.
 C. Procainamide or quinidine.
 D. Diphenylhydantoin.
 E. All of the above.

(Continued on page 152)

VALIUM® IV
diazepam/
Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported: should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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Clinics for Crippled Children Listed for April

Forty-three clinics for Illinois' physically handicapped children have been scheduled for April by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 31 general clinics, 10 cardiac clinics one for myelodysplasia and one clinic for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

1 Cairo—Southern Seven Health Department
1 Hinsdale—Hinsdale Sanitarium
2 Litchfield—St. Francis Hospital
2 Sterling—Community General Hospital
2 Lake County Cardiac—Victory Mem. Hosp.
3 Division Cardiac—U. of I. at the Medical Center
6 Peoria Myelodysplasia—St. Francis Med. Center
7 Park Ridge Cardiac—AM—Lutheran General Hospital
7 Park Ridge General—PM—Lutheran General Hospital
7 Wheaton General—Marianjoy Rehab. Hosp.
8 Rockford—St. Anthony Hospital
8 Champaign—Urbana—McKinley Health Service Center
8 Chicago Heights General—St. James Hosp.
8 Joliet—St. Joseph's Hospital
9 Springfield General—St. John's Hospital
9 Aurora Cardiac—Mercy Center for Health Care Services
9 Kankakee General—St. Mary's Hospital
13 Peoria Cardiac—St. Francis Med. Center
13 Belleville—Belleville Memorial Hospital
13 Chicago Heights Cardiac—St. James Hosp.
13 Maywood—(Ortho/Ped/Neuro)—Loyola Medical Center
14 Quincy—Blessing Hospital
14 East St. Louis—Community Hospital
14 Danville—Lake View Hospital
14 Peoria—St. Francis Medical Center
15 Chicago Heights General—St. James Hosp.
15 Aurora General—Mercy Center for Health Care Services
16 Rockford—Rockford Memorial Hospital
16 Metropolis—Massac Memorial Hospital
16 Bloomington—Mennonite Hospital
16 Elmhurst Cardiac—Memorial Hospital of DuPage County
20 Maywood—(Ortho/Ped)—Loyola Medical Center
21 Rock Island Area General—Moline Public Hospital
21 Maryville—Oliver C. Anderson Hospital
21 Decatur—Decatur Memorial Hospital
22 Springfield Ped-Neuro—St. John's Hosp.
22 Elgin General—Sherman Hospital
23 Anna—Union County Hospital
24 Evanston—St. Francis Hospital
24 Kankakee Cardiac—St. Mary's Hospital
27 Peoria Cardiac—St. Francis Med. Center
27 Chicago Heights Cardiac—St. James Hosp.
27 Maywood—(Ortho)—Loyola Medical Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,
Department of Radiology, Loyola University Stritch School of Medicine



Figure 1
A lesion of the distal tibia in a 20 year old boy examined for acute trauma to the ankle.



Figure 2
A lesion of the distal femur (arrows) in a 46 year old man with knee pain for six months.

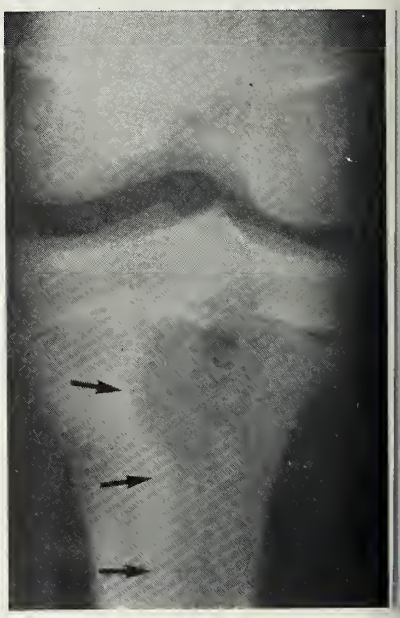


Figure 3
A metaphyseal lesion of the proximal tibia (arrows) in a 13 year old boy with knee pain for two months.



Figure 4
A lesion of the proximal phalanx of the little finger in a 4 year old girl with painless swelling.

Two of these primary bone neoplasms are benign and two are malignant. Match the patient with the diagnosis.

1. Aneurysmal bone cyst
2. Fibrosarcoma
3. Non-ossifying fibroma (fibrous cortical defect)
4. Osteosarcoma

(Continued on page 201)

Abstracts of Action

January 24-25, 1981 **Chicago**

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

FINANCIAL/ADMINISTRATIVE MATTERS

The Board approved a 1981 ISMS budget reflecting an income of $2,516,807 and expenses of $2,523,807. The deficit is the result of a $7,000 increase in allocation to ICCME over the amount recommended by the Finance Committee. In other actions involving finances, the Board:

- Approved a 1981 Benevolence Fund budget of $57,074 income and $62,000 expenses. ISMS will not make an allocation to the Fund this year because assets are sufficient to cover recipient grants.
- Authorized allocation of any 1980 income exceeding expense to the contingency reserve for use in future years.

Acting on administrative matters, the Board:

- Authorized introduction of a resolution urging the House of Delegates to delete a bylaws requirement that the House meet twice each year. The proposal would allow the Board of Trustees to cancel—at least 90 days in advance—the Interim Session if there is not sufficient, relevant business. In that case, a "leadership-type" program—offering CME credit—would be scheduled. In addition, the resolution will call for streamlining the Interim Session to allow time for educational programs even if a business meeting is held. County medical and specialty society officers would be invited to attend both the House meetings and special programs.
- Discharged the Task Force on New Health Practitioners and created a committee under the Council on Education and Manpower to assume Task Force responsibilities.
- Transferred the Eye Health Committee from the Governmental Affairs Council to the Council on Affiliate Societies.
- Approved changes in the bylaws of the ISMS Student Business Section.

FRIEND-OF-THE-COURT BRIEF

ISMS will file a friend-of-the-court brief in the Illinois Supreme Court supporting Alton Memorial Hospital's appeal of a court ruling—issued in a malpractice suit—which threatens confidentiality provisions of the Medical Studies Act. That Act prohibits disclosure of information used in internal quality control or for improving patient care obtained by IDPH, ISMS, allied medical societies, Ill. State Medical Inter-Insurance Exchange or committees of accredited hospitals.

In the malpractice suit, the court ruled that proceedings of the hospital Quality of Care Review Committee must be provided to determine if issues in that review are relevant to the personal injury action. The hospital refused to release the records and was held in contempt of court. An appellate court upheld the trial court's decision. When a petition for a rehearing was denied, the hospital announced it would appeal the matter to the Supreme Court.

BLOOD BANKING

The Board approved plans to transform the ISMS-sponsored Statewide Blood Banking Coordinating Committee into a free-standing organization by next January. The Committee—including representatives of all blood banks serving Illinois—was created two years ago in response to a House of Delegates directive that ISMS assist appropriate agencies in establishing a regionally-coordinated statewide blood banking system. ISMS—through its Educational and Scientific Foundation—recently received the first installment of a $250,000 Chicago Regional Blood Program grant to fund activities aimed at improving blood inventories and distribution. CRBP is discontinuing operations and issued the grant to support programs that will fill the void.

(Continued on page 186)

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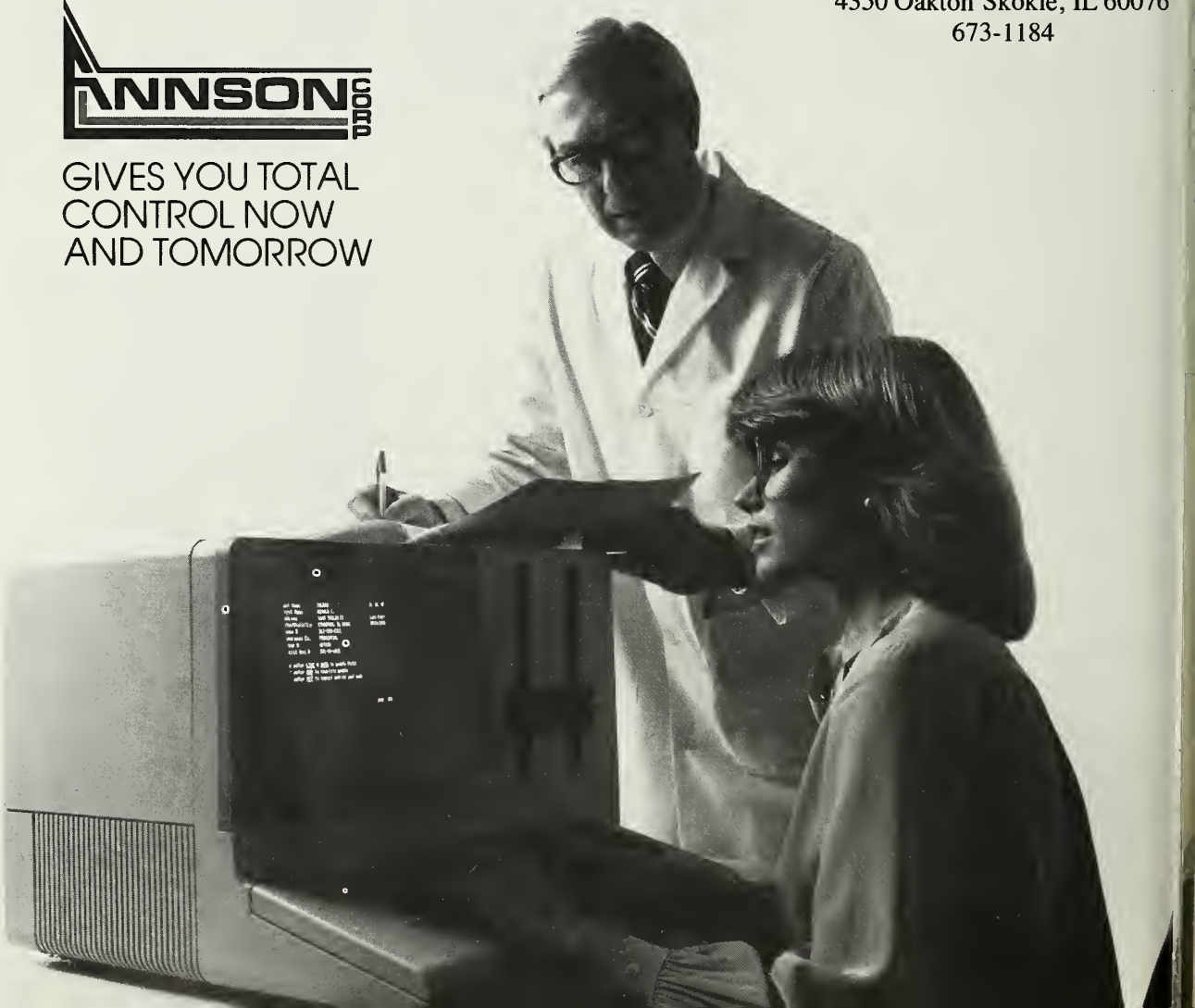
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Pulse of the ISMS Auxiliary

Leadership—What Is It?

BY MRS. HARLAN FAILOR, ISMSA PRESIDENT



(L-R) Mrs. Louis Tarsinos, District 2 councilor, Mrs. Jane Swanson, ISMSA executive secretary, Mrs. K.M. Nelson, president of Bureau County, Mrs. Harlan Failor, ISMSA president and Mrs. Harold Keegan, ISMSA president-elect, at Leadership Seminar-North, Bureau Valley Country Club.

In a Long Range Planning survey which was sent to County officers before the current year began, the question was asked, "What is the primary purpose of the State Auxiliary?" The respondents answered, (almost unanimously) "To assist Counties with health programs and projects and to provide leadership."

The first responsibility is a tangible one, readily assumed by the State Auxiliary. We have a Project Bank, twelve Package Programs, and a team of Health Chairmen willing to travel.

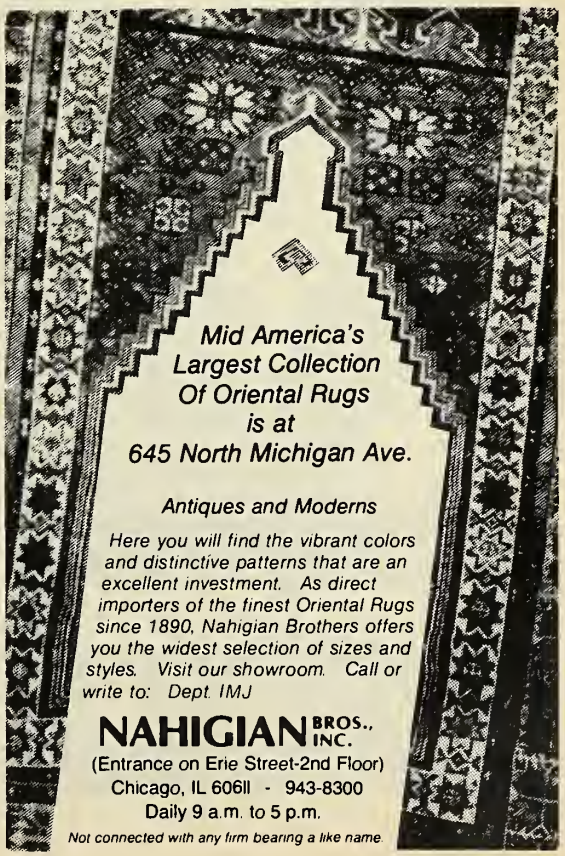
The second responsibility is somewhat nebulous. Does providing leadership mean taking by the hand, or does it mean supplying a good map and some words of encouragement? To the ISMS Auxiliary it has meant training—the teaching of skills and management by objective. It has meant showing the way—yet encouraging independence.

To accomplish all of this, two Leadership Seminars were planned and presented last September by the State's President, Mrs. Harlan Failor, President-Elect, Mrs. Harold Keegan, and three Vice-Presidents, Mrs. Don Hinderliter, Mrs. Gamil Arida, and Mrs. Irvin Blumfield. One was held in the northern half of the state at the Bureau Valley Country Club near Princeton, and the other in the southern half of the state at Pere Marquette State Park near Grafton. The Seminars were subtitled "Enhancing Our Image," and they touched upon every aspect of Auxiliary leadership, from parliamentary procedure to fund raising, from membership recruitment to public relations. All in attendance declared the Seminars a success.

What then, is leadership? According to Michael J. McCarthy, who spoke at the AMA Auxiliary's Leadership Confluence last October, "Leadership is the ability to get things done through others." Max Cleland says "Motivating, developing, promoting others is what it's about. But probably the simplest definition is "Being willing to go *first* where you want others to follow."

That definition seems to reiterate what we have sensed all along: If we are seeking to guide others to anything—including a healthy lifestyle—we must *first* set the example.

No one said being a leader was *easy!*



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EKG

(Continued from page 136)

Answers: 1. E 2. A. B.

The sick sinus syndrome refers to a combination of clinical signs, symptoms and ECG findings. The patient complaints are often syncope or near syncope or some neurologic complaint. In our patient, blurring of vision correlated with periods of asystole. The top line of the ECG panel shows a coarse atrial fibrillation or atrial flutter-fibrillation. The ventricular response of approximately 100 beats/minute is adequate but the mechanism is very unstable. In the middle ECG strip, atrial fibrillation converts to a sinus rhythm, but asystole occurs first. There is a 7.8 second pause of asystole. During this time, the patient complained of blurring vision. His initial complaint of unilateral visual difficulty suggested carotid artery disease, but this was not confirmed by angiography. The bottom ECG strip starts with a shorter asymptomatic, asystolic period. Both periods of asystole end with a single sinus beat and then atrial fibrillation returns. Had the patient remained in atrial fibrillation, he could have been relieved of periods of asystole. Unfortunately, atrial fibrillation was not stable. The sick sinus would not recover quickly enough and asystole would occur. Another important aspect of the ambulatory ECG is the failure of all subsidiary pacemakers. In addition to sinus node dysfunction, all atrial, junctional, and ventricular pacemakers were also failing. Failure of the escape subsidiary pacemakers as well as the sinus node lead to the periods of asystole.

These ECG abnormalities do not give an etiology for the sick sinus syndrome. In addition to coronary heart disease, idiopathic fibrosis of the sinus node, inflammatory conditions, cardiomyopathies, collagen disease, amyloidosis, and other causes result in the sick sinus syndrome. Prognosis in any individual patient is related to the underlying heart disease. Treatment with drugs to control the atrial fibrillation might make matters worse, as they would further depress the sinus node. A pacemaker is required. Once the demand ventricular pacemaker guarantees a minimum heart rate, then digoxin would control the rapid ventricular rate caused by atrial fibrillation. Usually this would be sufficient treatment. In some cases, quinidine or procainamide might be required. In our patient, the pacemaker and digoxin controlled his arrhythmia. His severe angina and coronary artery disease required a triple saphenous vein aortacoronary bypass surgery. ◀

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Pain Threshold Neuro-Modulations

By EUGENE J. ROGERS, M.D., F.A.C.P./CHICAGO

Twenty-two healthy volunteers were tested for correlation of six mood states with pain threshold levels as measured by response to electric current. These pain thresholds, reported by others to be constant, were found to vary from subject to subject, within subjects during the day, and from day to day. There was no significant correlation between the mood states and pain thresholds. Those variations may be due to many factors, including neurotransmitter substances.

This preliminary study simultaneously evaluated pain thresholds and six mood states in 22 healthy volunteers. Although pain thresholds have been reported as constant for all individuals,[1-5] we found that the intensity of electric current required to elicit pain was inconstant with significant intra-day, inter-day, and subject variation. No significant correlation existed between pain thresholds and mood states. Other regulatory mechanisms may alter and regulate these pain thresholds. These include hormonal variations, particularly of the neurotransmitter systems such as enkephalins.

Method

The subjects were 22 healthy volunteers at the North Chicago VA Hospital selected from among office staff, allied health personnel, and medical students. Age range was 18 to 63 with 18 subjects between 20 and 49. Each signed an informed consent form after full disclosure of the study's purpose and procedures to be used.

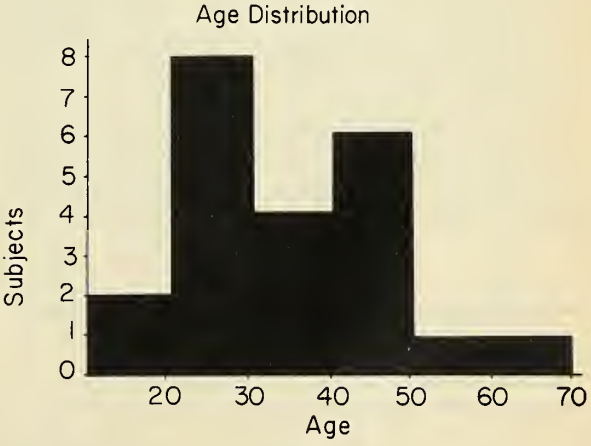
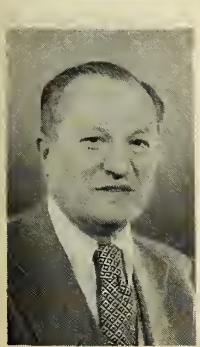


Table 1

Subjects were asked to indicate "pain" for initial perception of any type of pain or noxious sensation in response to electrical stimulation. No further conversation or comments were made.

Subjects were positioned so as to be unable to



EUGENE J. ROGERS, M.D., F.A.C.P., board certified in physical medicine and rehabilitation, is professor and chairman, department of rehabilitation medicine, University of Health Sciences/The Chicago Medical School. Dr. Rogers, a member of the *IMJ* Editorial Board, has held numerous professional positions, including chairmanship of the ISMS Committee on Workmen's Compensation.

observe the stimulator meter readings. Each volunteer completed a numerically weighted mood adjective self-assessment questionnaire reflecting anger, fatigue, activity, depression, fear and happiness.[6]

Table 2

MOOD ADJECTIVE TEST

Below is a list of words describing moods and feelings. Indicate how each word applies to how you feel right now by placing a 1, 2 or 3 in the blank after each word (1 = not at all, 2 = somewhat or slightly, and 3 = mostly or generally.)

Lively	Low
Irritated	Weary
Afraid	Contented
Blue	Mean
Lazy	Alarmed
Active	Miserable
Burned Up	Drowsy
Uneasy	Calm
Downcast	Grouchy
Sluggish	Hopeless
Steady	Depressed
Annoyed	Inactive
Insecure	Happy
Sad	Angry
Jittery	Pleased
Satisfied	Energetic
Cheerful	Vigorous
Alert	Good

A moist heat pack was applied to the forearm while completing the mood adjective test.

A stimulating electrode measuring 2.5cm in diameter was placed over the central volar aspect of the heated forearm, approximately 7.5cm distal to the elbow crease. The 5.0x7.5cm dispersing electrode was placed over the dorsal aspect midthird of the forearm.

A pulse generator and chronaxie meter TECA (Model CH5) with current selection at rheobase was utilized to induce a rectangular pulse, 300 milliseconds in duration, with an interval of .1 second between pulses. This unit automatically maintains the current output at the intensity level set regardless of variations in electrode or patient resistance.

The mood states and pain thresholds were determined for each subject twice daily on six separate days for a total of 12 determinations.

Results

The mood states of happiness, fatigue, anger, depression, activity and fear showed no significant statistical correlations with these pain thresholds.

The average pain threshold for all individuals was 5.92 with a standard deviation of 2.8.

Individual average differences were as high as 7.1 and as low as .8. The maximum reading during the 264 test sessions was 14.5ma and the lowest .3ma. The AM pain threshold mean was 6.22ma, standard deviation 2.85 and the PM pain threshold was 5.61ma, standard deviation 2.77. Three subjects had pain thresholds between 2-3ma, 4 between 3-4ma, 3 subjects each between

FIGURE I

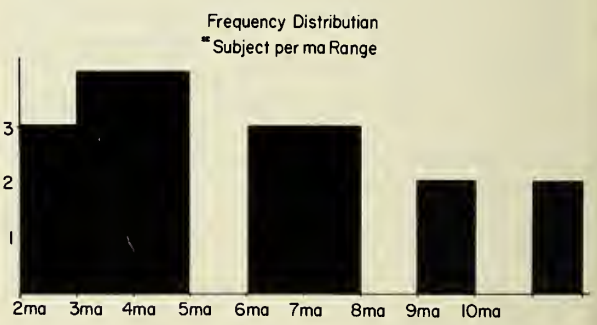


Table 3

Mood Adjective Test and Pain Threshold Correlations

	R VALUE	Z VALUE	Z ETAR	SIGMA
Pain Threshold and Anger	−0.1299	−0.5696	−0.1307	0.2294
Pain Threshold and Fatigue	.0757	.3308	.0759	0.2294
Pain Threshold and Repression	.0734	.3206	.0735	0.2294
Pain Threshold and Activity	.2430	1.0809	.2480	0.2294
Pain Threshold and Happiness	.2813	1.2600	.2891	.2294
Pain Threshold and Fear	− .0278	− .1210	− .0278	.2294

Table 4

Pain Threshold Experiment

SUBJECT	AGE	AM-1	PM-1	AM-2	PM-2	AM-3	PM-3
1	53	9.2	7.7	12.4	14.5	13.4	11.8
2	19	2.9	2.6	2.7	2.9	3.1	3.1
3	40	5.9	5.8	8.3	7.0	7.3	6.8
4	18	6.9	5.8	8.0	6.4	6.8	6.5
5	23	9.0	6.7	6.8	8.5	6.4	7.4
6	38	6.3	4.6	4.5	3.8	6.5	4.7
7	48	3.3	4.0	4.0	3.3	4.7	3.9
8	28	6.8	6.8	4.8	4.2	5.9	5.0
9	41	4.2	3.2	3.9	2.8	3.6	3.3
10	25	12.8	11.4	7.0	6.5	9.5	8.5
11	22	5.4	7.0	8.5	9.4	10.5	9.5
12	44	3.3	2.7	2.2	1.9	1.6	1.0
13	25	7.8	6.9	8.6	7.9	9.4	6.5
14	38	4.9	1.4	6.8	6.8	7.2	7.0
15	41	3.5	3.5	3.7	3.6	4.5	2.5
16	63	6.2	5.0	5.0	7.4	7.8	6.9
17	21	4.0	3.6	5.2	5.3	6.1	5.1
18	28	2.3	1.4	2.2	1.8	2.0	2.0
19	41	10.3	9.0	11.4	10.6	10.7	12.0
20	35	4.0	2.8	4.5	3.5	4.9	4.9
21	35	4.9	2.5	4.0	3.5	3.5	3.8
22	26	3.0	1.9	0.5	0.3	2.1	2.4
		5.77	4.83	5.68	5.54	6.25	5.66

SUBJECT	AGE	AM-4	PM-4	AM-5	PM-5	AM-6	PM-6	AVERAGE	HIGH-LOW DIFFERENCE
1	53	10.4	11.2	13.6	11.1	13.9	11.6	11.8	6.8
2	19	3.9	3.1	3.0	2.8	4.2	3.0	3.1	1.6
3	40	7.0	7.1	6.4	5.5	6.3	5.8	6.6	2.8
4	18	8.5	6.9	7.3	6.8	6.8	7.5	7.1	2.8
5	23	4.6	6.8	4.4	5.9	4.6	5.4	6.4	4.6
6	38	7.3	4.0	5.1	4.5	4.1	4.4	5.0	3.5
7	48	5.7	5.5	4.9	4.4	6.5	5.5	4.6	3.2
8	28	9.0	6.5	10.4	8.0	8.9	6.0	6.9	6.2
9	41	2.6	3.3	3.9	3.6	3.5	3.4	3.4	1.6
10	25	12.0	8.6	9.8	8.5	10.1	10.0	9.6	5.5
11	22	10.5	10.4	9.5	10.3	9.0	10.9	4.2	5.5
12	44	2.8	2.0	2.5	2.0	2.3	3.0	2.3	2.3
13	25	8.1	5.1	7.7	4.4	10.4	8.4	7.6	6.0
14	38	7.0	7.5	8.5	7.4	8.1	6.6	6.6	7.1
15	41	3.9	4.8	4.8	4.0	4.8	2.8	3.9	2.3
16	63	8.2	9.5	9.2	7.3	11.4	8.5	7.7	6.4
17	21	5.1	3.9	5.0	4.7	4.5	3.9	4.7	1.7
18	28	2.1	2.0	2.1	2.0	2.2	2.0	2.0	.8
19	41	11.0	11.5	11.6	12.0	12.6	11.4	11.2	3.6
20	35	5.1	4.5	6.0	4.0	5.5	4.5	4.5	3.2
21	35	4.0	3.1	5.7	3.5	5.0	4.3	4.0	3.2
22	26	2.2	2.8	2.3	3.4	3.3	3.7	2.3	3.2
		6.41	5.91	6.53	5.73	6.73	6.0	5.8	3.81
								SD 2.8	SD 1.88

6-7ma and 7-8ma and 2 each between 9-10ma and 11-12ma. Subjects appeared widely dispersed in their pain thresholds.

These preliminary results would indicate a marked variation in the pain thresholds for the individuals tested not only from session to session, but also from individual to individual. The intra-day variations of all subjects showed a significantly higher threshold in the AM (T 4.25 p .001).

Discussion

Experimental pain thresholds are reported to depend upon physiological factors. When evalu-

ated in the same part of the body, they tend to be the same even when elicited by different stimuli and the characteristic of this pain is perceived differently.[1] Experimental pain beyond the threshold level is more variable and the standard deviations are greater.[2] McKenna[3] indicated that the pain threshold, the point at which the sensation of pain is noted, is quite constant from subject to subject. The constancy of pain thresholds for all individuals has been confirmed by others.[4,5] Lloyd, *et al.*,[7] report that placebo and suggestion modify bias but not pain threshold sensitivity.

The pain thresholds have been reported to increase with aging,[8] to be decreased in females[3,9] and to be higher in the morning than late afternoon.[10]

This study revealed fluctuations in pain thresholds between individuals and within the same subjects. These variations were not related to mood states and thus warrant further explanations beyond aging and sex.

Hughes[11] has isolated an endogenous analgesic substance from brain areas rich in morphine receptors. This endogenous morphine-like substance, endorphin, when injected, induced analgesia, is antagonized by naloxone and readily destroyed by carboxypeptidase A and leucine aminopeptidase.

A review[12] of neurotransmitters indicates multiple steps in the transmission system. Peptides (*i.e.*, endorphins) and amino acids act as first messengers on receptor organs that then affect second messengers intracellularly. The concentrations of these neurotransmitters, the rate at which they are liberated and their enzymatic degradations are subject to various influences. D-phenyl alanine and hydrocinnamic acid inhibit carboxypeptidase.[13] Dehen, *et al,*[14] report a case of congenital insensitivity to pain and postulate a tonic hyperactivity of a morphine-like pain inhibitory system antagonized by naloxone.

Fields, *et al,*[15] suggest that pain thresholds are not sensitive to endogenous analgesic systems. Yet they simultaneously state that somatosensory stimuli of thermal or noxious quality produce analgesia in the same or other regions by activating this endogenous analgesic system. Narcotic antagonists (naloxone) block enkephalins and reverse the analgesic action of somatosensory stimuli.

Beta-endorphins are liberated from the pituitary gland[16] and hypophysectomy abolished analgesia.[17] ACTH and beta-endorphins have similar precursers and may be liberated concurrently[18] and depressed by dexamethasone.[19] Other endorphins have also been found in the cerebrospinal fluid.[20,21]

We postulate that variations in the number of target organs available, hormones and neurotransmitters liberated and degraded could explain the variations in the pain thresholds among individuals and within the same subject.

Summary

Twenty-two healthy volunteers received electric current stimuli twice daily on six separate days to ascertain their pain thresholds. Six mood states were evaluated prior to each test session. No correlation was noted between the mood states of anger, fatigue, activity, depression, fear and happiness and the pain thresholds. Investigators indicate that pain thresholds are constant from subject to subject and similar for identical body areas regardless of stimulus. Our study showed pain threshold variations do exist from AM to PM, from day to day and from individual to individual. We hypothesize that variations are due to interrelationships of many factors, hormones and neurotransmitters liberated and degraded and number of target organs available. This warrants further exploration. ◀

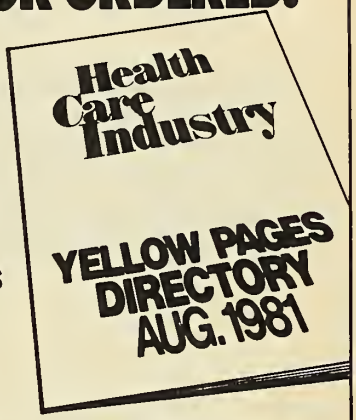
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Say It In Triplicate

I am enthusiastic about progress in medicine. But I wonder about some recent changes. Do they represent progress? In our Emergency Room, we now fill out reports in five copies. A state voucher for a simple examination calls for six carbon copies. The hospital administrative people, even physicians, are molded to the image and likeness of government bureaucracy.

Recently, I inquired about a 12-year-old hospital record. The librarian informed me that all the old charts are shipped for microfilming. This fascinated me, since this old record was useless to anyone except me. Apparently, seven thousand hospitals in this US microfilm perhaps as much as a hundred million charts dating back to the 40s, 30s or even further. It is difficult to understand why we immortalize the history that Jo Doe was itching with scabies or took his liquid diet in 1948.

In defense of this currently fashionable practice it is said that: (1) The bureaucratic dogma is that it is good practice to microfilm everything; (2) This is a great pool of scientific data. There is limited justification in a research hospital setting. (3) It is economical (in fact it is expensive); (4) The lawyers delight that they can now sue another generation.

These are sad justifications. Can we call this love of the records of the dead: *Idiopathic Bureaucratic Necrophilia?* Of course not, although we all love old things at times. But we could call it: *Secondary Bureaucratic Necrophilia.*

When bureaucracy mushrooms, powerful motives are not hard to find. And there are many: (1) Microfilming of medical records has created its own bureaucracy which will fight for its existence; (2) Microfilming has generated a multimillion dollar business and technology. These business interests are powerful enough to protect their profits; (3) Microfilming has also gained academic recognition. It is not hard to find a professor to testify that the very survival of our civilization depends on preservation of old records; (4) As hospital records increase in size almost daily, the future of microfilming is unlimited.

The current carbon copy and microfilming epidemics are the signs of a wealthy nation which can afford to spend millions on dubious or worthless bureaucratic routines. It is also the sign that we are losing the control of our profession. Bureaucracy is in control now. We should stop complaining about high medical bills. The excesses of carbon copies and microfilming should be restricted by law. This would be a wonderful start to reduce the cost of health care. ◀

James Scott, M.D.
Streator

Poetry

THE DOCTOR'S WIFE
(Dedicated to My Elsie)

Among the heroines oft unsung
As they travel the highway knov
as Life
Is an oft unrecognized noble heart
The woman known as a doctor
wife.

She stays in the background wi
her strength
No less than the doctor she hel
with a will
Her sacrifice seldom acknowledg
or known
A saint in this world, a boon to t
ill.

For from her, the doctor, her so
and her girls
Derive their courage, their driv
and their skill
As a country supports her troops
the front
So, onward together, they ke
marching still.

When crowns are worn in a happ
world
And halos are passed in a better li
They will glow in the smile of t
Blessed One
As He crowns, with His blessi
the doctor's wife.

Herman L. Meltzer, M
Clin

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County	President	Secretary
Edgar Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham Members: 19-Dist. 7	Robert Farmer St. Anthony Mem. Hospital., Effingham 62401	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401
Fayette Members: 7-Dist.7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth Str., Vandalia 62471
Ford Members: 11-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
Franklin Members: 29-Dist. 9	Talifaldis Kisle 502 W. Franklin, Sesser 62884	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
Fulton Members: 42-Dist. 4	Jai Chul Cha 210 W. Walnut, Canton 61520	John H. Day 175 W. Main, Canton 61520
Gallatin Members: 2-Dist. 9		John E. Doyle Ridgway 62979
Greene Members: 6-Dist. 6	Jose P. Parcon 11 Edgewood Drive, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
Hancock Members: 12-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson Members: 2-Dist. 4	Farouk El Khatib Stronghurst Med. Cntr., Stronghurst 61480	Silvino Lindo, Jr. Biggsville 61418
Henry-Stark Members: 35-Dist. 4	Renato Judalena 513 Elliott St., Kewanee 61443	Hipolito C. Lopez, Jr. 716 Elliott, Kewanee 61443
Iroquois Members: 22-Dist. 11	C. P. DeVas Gunawardhane PO Box 638, Clifton 60972	Jeffery Swider 106 Prof. Arts Bldg., Rts 1 & 24E Watseka 60970
Jackson Members: 109-Dist. 9	Antoinette G. Thomas 404 W. Main, Carbondale 62901	Adiraju Palagiri 2601 W. Main, Carbondale 62901
Jasper Members: 2-Dist. 8	Monico Low 609 S. Van Buren, Newton 62448	Juan J. Serra 507 W. Washington, Newton 62448
Jefferson-Hamilton Members: 37-Dist. 9	H. Goff Thompson 1708 Jefferson, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
Jersey-Calhoun Members: 11-Dist. 6	Robert G. Mindrup 300 S. Washington, Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
Jo Daviess Members: 8-Dist. 12	David Hockman 300 Summit St., Galena 61036	Wilbur Johnson 300 Summit St., Galena 61036
Kane Members: 323-Dist. 1 H. Michael Wild, Ex. Dir. 202 Campbell Geneva 60134	William T. Sheehy 1187 Dundee Ave., Elgin 60120	John A. O'Dwyer 34 N. Water, Batavia 60510
Kankakee Members: 109-Dist. 11	Donald Parkhurst 401 N. Wall, Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
Kendall Members: 8-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
Knox Members: 81-Dist. 4 Mrs. Jane Gau, Exec. Sec. Galesburg Cottage Hospital 695 N. Kellogg Galesburg, IL 61401	Gene E. Johnson 3315 N. Seminary, Galesburg 61401	Martin D. McDermott 555 N. Kellogg, Galesburg 61401
Lake Members: 433-Dist. 1 Julia Schultz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	James R. Creath 1345 Wilson Dr., Lake Forest 60045	Ronald R. Klimaitis 158 E. Cook, Libertyville 60048

County	President	Secretary
LaSalle Members: 109-Dist. 2	Eleanor E. Howell 811 N. Bloomington, Streator 61364	Alfan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence Members: 13-Dist. 8 Ruth Gariepy, Ex. Sec. Lawrence Cty. Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Francisco E. Martin 542 N. Main, Bridgeport 62417
Lee Members: 25-Dist. 12	Wilbur L. Stitzel KSB Hosp., 403 E. First St. Dixon 61021	Joseph Elie McNichols Clinic, 120 S. Hennepin Ave. Dixon 61021
Livingston Members: 27-Dist. 2	Rajenda Shrivastav 612 E. Water, #107, Pontiac 61764	Karl T. Deterding 612 E. Water, Pontiac 61764
Logan Members: 25-Dist. 5	Edward Ulrich 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
Macon Members: 167-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Giles Richard Locke 2300 N. Edward, Decatur 62521	H. Gale Zacheis 2220 N. Monroe, Decatur 62526
Macoupin Members: 19-Dist. 6	Robert H. Rutherford 224 E. Main, Carlinville 62626	Robert England 935 Morgan, Carlinville 62626
Madison Members: 203-Dist. 6	Laurence A. Heineman 1100 Broadway Ave., Highland 62249	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion Members: 41-Dist. 7	Louis E. Jorel Rt. 37 North, Salem 62881	W. P. Plassman Box 552, Centralia 62801
Marshall-Putnam Members: 3-Dist. 2	Joe W. Cannon 202 S. Main, Lacon 61540	Donald M. Gallagher Box 538, Granville 61326
Mason Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
Massac Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
McDonough Members: 30-Dist. 4	Budris Andernovics Industry 61440	David Reem 505 E. Grant, Macomb 61455
McHenry Members: 80-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Ted L. Rolander 1110 N. Green, McHenry 60050	Robert E. Stanell 3516 W. Waukegan Rd., McHenry 60050
McLean Members: 130-Dist. 5 Carol Toperzer, Exec. Sec. 1236 E. Empire Bloomington 61701	Douglas R. Bey 900 Franklin, Normal 61761	John R. Krueger #1 Medical Hills Dr., Bloomington 61701
Mercer Members: 4-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	Dennis D. Palmer 409 NW Fourth, Aledo 61231
Monroe Members: 10-Dist. 10	Ingeborg M. Kremer 854 Bottom, Columbia 62236	Chong K. Park 415 W. South 4th, Red Bud 62278
Montgomery Members: 22-Dist. 5	Roger Wujek 1215 E. Union, Litchfield 62056	James T. Foster 8 Arrowhead Rd., Litchfield 62056
Morgan-Scott Members: 51-Dist. 6	Robert M. Roy 1515 W. Walnut, Jacksonville 62650	Jeffery L. Belden 200 W. State, Jacksonville 62650
Moultrie Members: 4-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951

County	President	Secretary
Ogle Members: 18-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
Peoria Members: 410-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st National Bank Bldg. Peoria 61602	Stuart S. Roberts 427 1st Nat'l. Bank Bldg., Peoria 61602	Frederick Heinzen 427 1st Nat'l. Bank Bldg., Peoria 61602
Perry Members: 14-Dist. 10	Gene Stotlar 13 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
Piatt Members: 4-Dist. 7	George Green 121 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike Members: 11-Dist. 6	Warren C. Barrow 321 W. Washington, Pittsfield 62363	T. C. Bunting 321 W. Washington, Pittsfield 62363
Pulaski Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
Randolph Members: 21-Dist. 10	Allan L. Liefer 415 W.S. Fourth, Red Bud 62278	J. M. Whittenberg 1650 State St., Chester 62233
Richland Members: 24-Dist. 8	Don F. Hatten 408 N. Mill St., Olney 62450	Chandra Varadachari Richland Memorial Hosp., Olney 62450
Rock Island Members: 201-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	Robert M. Wells 2508-25th, #F, Rock Island 61201	Miguel Flores 532 19th, Moline 61265
St. Clair Members: 263-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main Belleville 62223	Thomas P. Meirink 8601 W. Main, Belleville 62223	Casimiro C. Garcia, Jr. 8601 W. Main, Belleville 62223
Saline-Pope-Hardin Members: 33-Dist. 9	Elliott O. Partridge 1201 Pine, Eldorado 62930	Warren R. Dammers P.O. Box 281, Harrisburg 62946
Sangamon Members: 400-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza Springfield 62701	P. F. Mahon 1 N. Old State Capitol Plaza Springfield 62701	Michael C. Snyder 800 E. Carpenter, Springfield 62702
Schuyler Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby Members: 8-Dist. 7	P. D. Gurujal Shelby Cty. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson Members: 55-Dist. 12	Frederick Mosher 1036 W. Stephenson, Freeport 61032	George Lagen 1045 W. Stephenson, Freeport 61032
Tazewell Members: 68-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Mahboob A. Sheikh P.O. Box 778, Pekin 61554	Robert F. Gregorski P.O. Box 778, Pekin 61554
Union Members: 9-Dist. 9	Thomas W. Davis 319 S. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Anna 62906
Vermilion Members: 108-Dist. 8	Edward N. Hetherington 715 W. Fairchild, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
Wabash Members: 5-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863

County	President	Secretary
Warren Members: 14-Dist. 4	Kenneth E. Ambrose 219 E. Euclid, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington Members: 6-Dist. 10	Ralph Kelley 113 W. St. Louis, Nashville 62263	Charles Longwell 111 S. Washington, Nashville 62263
Wayne Members: 9-Dist. 9	Eugene B. Loftin 301 NW 11th, Fairfield 62837	Charles J. Jannings 301 NW 11th, Fairfield 62837
White Members: 8-Dist. 9	Phillip D. Boren Doctors Clinic, Carmi 62821	Morris A. McCall Doctors Clinic, Carmi 62821
Whiteside Members: 54-Dist. 12	Reda M. Salama 1601 First Ave., Sterling 61081	Girish Bhatt 101 E. Miller Rd., Sterling 61081
Will-Grundy Members: 265-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Daniel Gutierrez 1255 Eagle St., Joliet 60432	Amin M. Khater 1106 N. Larkin, Joliet 60435
Williamson Members: 36-Dist. 9	M. T. Joseph 106 S. Vicksburg, Marion 62959	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago Members: 413-Dist. 12 Robert Carlson Exec. Adm. 310 N. Wyman St. Rockford 61101	Robert H. Lund 2300 N. Rockton, Rockford 61101	William E. Kobler 5727 Strathmore, Rockford 61107
Woodford Members: 7-Dist. 2	Hans W. Riggert 101 S. Davenport, Metamora 61548	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society

Edwards
Johnson
Menard

Joint County Societies

Cass-Brown
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Marshall-Putnam
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (October.) Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME:_____ CITY:_____ ZIP: _____

ADDRESS:_____

TELEPHONE: () _____

COUNTY MEDICAL SOCIETY:_____

MEDICAL SPECIALTY AND TYPE OF PRACTICE:_____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE:_____

SENT TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

Agenda

1981 House of Delegates

Robert P. Johnson, M.D., *Speaker*

Clifton L. Reeder, M.D., *Vice-Speaker*

FIRST SESSION

10:00 a.m.—Sunday, April 5, 1981
Grand Ballroom
Radisson Hotel
Chicago

1. Call to order
 Robert P. Johnson, M.D., *Speaker*
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Approval of minutes of previous meeting
6. Memorial Service for deceased members since April, 1980 conducted by Eugene P. Johnson, M.D., *Secretary-Treasurer*
7. Report of Chairman, Board of Trustees
 Morris T. Friedell, M.D.
8. Remarks of Speaker
9. Resolutions and supplementary reports
10. New business and announcements
 Reference Committees—1:30 p.m.
 Delegates' Brunch—11:30 a.m.-1:00 p.m.
11. Recess until 3:00 p.m.—Monday, April 6, 1981

SECOND SESSION

3:00 p.m.—Monday, April 6, 1981
Grand Ballroom
Radisson Hotel
Chicago

1. Call to order by speaker
2. Report of Committee on Rules and Order of Business
3. Report of Credentials Committee
4. Reports of special guests
 Mrs. Harlan Failor, *President,* Illinois State Medical Society Auxiliary
 Mrs. Elaine Kaiser, *President,* Illinois Society, American Association of Medical Assistants
5. Introduction of special guests
6. Presentation of certificates of appreciation to Continuing Medical Education Examiners
7. Presentation of AMA-ERF check to Illinois medical schools
8. IMPAC Report
 Paul Mahon, M.D., *Chairman*
9. Report of Executive Administrator
 Mr. Roger N. White
10. Introduction of AMA Delegates and Alternate Delegates
 Theodore Grevas, M.D., *Chairman*
11. President's Address
 Herschel Browns, M.D.
12. New business and announcements
13. Recess until 10:00 a.m.—Tuesday, April 7, 1981

THIRD SESSION

10:00 a.m.—Tuesday, April 7, 1981
Grand Ballroom
Radisson Hotel
Chicago

1. Call to order by the speaker
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Announcements and introduction of guests
6. Reports of Reference Committees
 - Amendments to Constitution and Bylaws
 - Committee A—Officers, Administration, Finances and Budgets
 - Committee B—Government Health Programs, including National Health Insurance and Cost Containment
 - Committee C—Education, Manpower and Clinical Medicine
 - Committee D—Medical Service and Economic Matters Outside of Government Programs
 - Committee E—Governmental Affairs and Medical Legal
 - Committee F—Public Relations, Membership and Miscellaneous Business
7. Recess for luncheon
8. Reconvene 2:00 p.m.
9. New Business
10. Recess until 9:00 a.m.—Wednesday, April 8, 1981

FOURTH SESSION

9:00 a.m.—Wednesday, April 8, 1981
Grand Ballroom
Radisson Hotel
Chicago

1. Call to order by the Speaker
2. Invocation
3. Report of Committee on Rules and Order of Business
4. Report of Credentials Committee
5. Induction of Fred Z. White, M.D., President-Elect into office of President by Herschel Browns, M.D.
6. Address of President White
7. Announcements and introduction of guests
8. Reports of reference committees
9. Elections
 - Report of Nominating Committee
 - (a) President-Elect (CMS)
 - (b) 1st Vice President (DS)
 - (c) 2nd Vice President (CMS)
 - (d) Secretary-Treasurer
 - (e) Speaker of the House (CMS)
 - (f) Vice Speaker (DS)
 - (g) Trustees

DISTRICT	*TERMS EXPIRING*
First District	John Ring, M.D.
Third District	Morris T. Friedell, M.D.
Third District	Henrietta Herbolsheimer, M.D.
Sixth District	Robert R. Hartman, M.D.
Ninth District	Warren D. Tuttle, M.D.
Tenth District	Julian Buser, M.D.

 - (h) Delegates to AMA to take office January 1, 1982, and serve until December 31, 1983

Terms Expiring

Herschel Browns, M.D.
Howard C. Burkhead, M.D.
Jack L. Gibbs, M.D.
Theodore Grevas, M.D.
Morgan M. Meyer, M.D.
Maynard I. Shapiro, M.D.
Joseph Skom, M.D.

 - (i) Alternate Delegates to AMA to take office January 1, 1982, and serve until December 31, 1983

Terms Expiring

Alfred Clementi, M.D.
Allan L. Goslin, M.D.
Robert C. Hamilton, M.D.
Robert R. Hartman, M.D.
Eugene P. Johnson, M.D.
Lee Johnson, M.D.
Harold Lasky, M.D.
Cyril C. Wiggishoff, M.D.

 - (j) Judicial Panel to take office April 8, 1981 and serve until April, 1986
 Eugene P. Johnson, M.D., Casey, nominated by ISMS President
 - (k) Judicial Panel to take office April 8, 1981 and serve until April, 1984
 Allison Burdick, Jr., M.D., Chicago, to fill unexpired term of Howard C. Burkhead, M.D., Evanston
 - (l) Rules and Order of Business to take office April, 1981 and serve until April, 1982
 Five (5) Delegates nominated by the Speaker of the House
10. Fixing of per capita dues for 1982
11. Selection of meeting place and time for next meeting
12. Unfinished business
13. New business
14. Adjournment, Sine Die

Committees of the House of Delegates

1981 Annual Meeting

COMMITTEE ON RULES & ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedure, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof.

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

REFERENCE COMMITTEE A

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to officers, administration, finances and budgets.

REFERENCE COMMITTEE B

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to government health programs, including national health insurance and cost containment.

REFERENCE COMMITTEE C

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to education, manpower and clinical medicine.

REFERENCE COMMITTEE D

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to medical service and economic matters outside government programs.

REFERENCE COMMITTEE E

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to governmental affairs and medical legal matters.

REFERENCE COMMITTEE F

This committee shall consider and submit its recommendations to the House of Delegates upon reports and resolutions relating to public relations, membership and miscellaneous business.

Program Summary By Days

ISMS Annual Meeting

April 4-8, 1981

Radisson Hotel, Chicago

Saturday, April 4, 1981

9:00 a.m. Board of Trustees Meeting
10:00 a.m. Resident Physicians Section
1:00 p.m. Student Business Section
1:00 p.m. Substance Abuse: Clinical Aspects Seminar

Sunday, April 5, 1981

8:00 a.m. Registration
8:30 a.m. Meeting of Reference Committee Members
9:00 a.m. Credentials Committee
10:00 a.m. House of Delegates
11:15 a.m. IMPAC Annual Meeting
11:30 a.m. District Meetings
11:30 a.m.-1:00 p.m. Delegates' Brunch
1:30 p.m. Reference Committees

Monday, April 6, 1981

7:30 a.m. Public Affairs Breakfast
8:00 a.m. Registration
9:30 a.m. Leadership Conference
11:30 a.m. Fifty Year Club
1:15 p.m. ISMIE Membership Meeting
2:00 p.m. ISMIE Board Meeting
2:30 p.m. Credentials Committee
3:00 p.m. House of Delegates
5:00 p.m. District 1, 2, 4, 5, 6, 7, 8, 9, 10, 11, 12 Caucus
5:00 p.m. District 3 Caucus
7:00 p.m. President's Night

Tuesday, April 7, 1981

7:30 a.m. Board of Trustees Meeting
8:00 a.m. Registration
9:30 a.m. Credentials Committee
10:00 a.m. House of Delegates
12:00 noon Recess
2:00 p.m. House of Delegates

Wednesday, April 8, 1981

7:30 a.m. Board of Trustees Meeting
8:00 a.m. Registration
8:30 a.m. Credentials Committee
9:00 a.m. House of Delegates

Board of Trustees Reorganization Meeting immediately following House adjournment

ISMS DELEGATION TO THE AMA

Delegates

To serve from Jan. 1, 1980 to December 31, 1981
(Elected May 9, 1979)

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Jack L. Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Maynard I. Shapiro, Chicago
Joseph Skom, Chicago

To serve from Jan. 1, 1981 to Dec. 31, 1982
(Elected April 15, 1980)

David S. Fox, Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O,Donnell, Glen Ellyn
John J. Ring, Mundelein
Glen E. Thomlinson, Lincoln
George T. Wilkins, Granite City

Honorary Delegates

Walter C. Bornemeier, Saratoga, Cal.
Edwin S. Hamilton, Kankakee
Frank J. Jirka, Jr., Barrington Hills
Burtis E. Montgomery, Long Island, NY

Delegation Chairman: Theodore Grevas; Secretary: Howard C. Burkhead

Alternate Delegates

To serve from Jan. 1, 1980 to Dec. 31, 1981
(Elected May 9, 1979)

Alfred Clementi, Arlington Heights
Allan L. Goslin, Streator
Robert Hamilton, Chicago
Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Lee Johnson, Litchfield
Harold Lasky, Chicago
Cyril C. Wiggishoff, Chicago

To serve from Jan. 1, 1981 to Dec. 31, 1982
(Elected April 15, 1980)

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
Robert P. Johnson, Springfield
Boyd McCracken, Sr., Greenville
Clifton L. Reeder, Wilmette
Richard Rovner, Chicago
P. John Seward, Rockford

PHYSICIANS & AUXILIANS

join us
ISMS THEATRE PARTY
APRIL 7, 1981

EVITA

The International Musical Hit
Winner — Best Musical — 7 Tony Awards
100 seats have been reserved for our official family

Advance Registration is required. Seats are 1st Balcony Front @18.00
Checks payable to Illinois State Medical Society and mail to ISMS, 55 E. Monroe, Chicago, IL. 60603

Number of Tickets_____Check in the amount $_____

NAME_____
(please print)

ADDRESS_____

TICKETS WILL BE HELD AT ISMS REGISTRATION DESK

DEADLINE FOR TICKETS March 23, 1981 (no tickets can be sold after this date)

SBS PRESENTS

Student Business Section, Illinois State Medical Society

MEDICINE: 1990

MODERN ADVANCES IN HOSPICE MEDICINE

Michael Prerodor, M.D., Medical Director of the Horizon Hospice, Chicago:

Medicine deals not only with life and the living; physicians cannot ignore the aspects of death and dying. Hospice offers comfort and peace of mind for the terminal patients and their families

WHOLISTIC MEDICINE—THE ALTERNATIVE

Rosemary Rau-Levine, M.D., Child Psychiatrist, and Family Therapist: Staff Physician at Madison Wholistic Health Center, Madison, Wisconsin:

Wholistic Medicine considers the physical, mental and emotional aspects of the patient before treatment

COMPUTERS AT THE BEDSIDE—BOON OR BANE?

Allan H. Levy, M.D., Professor of Clinical Medicine; Professor of Computer Science; and Director of Medical Information Science, University of Illinois, Urbana Champaign:

The physician of 1990 will have access to the computer, which will help in diagnosis and treatment

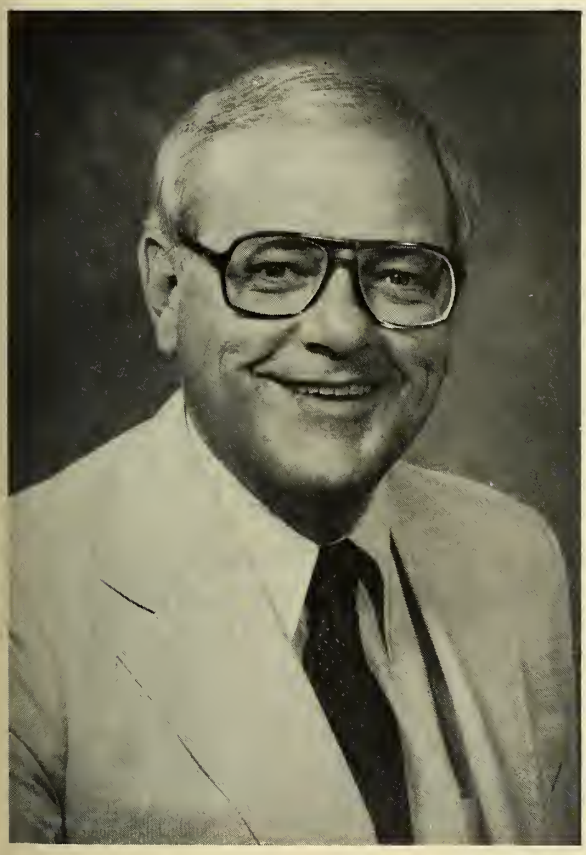
This program offers three (3) hours of Category 2 CME credit for physicians.

ISMS/SBS Annual Meeting—4:00 P.M.

SATURDAY, APRIL 4, 1981, 1-4 P.M.
Radisson Hotel, 505 N. Michigan Avenue
Chicago, Illinois
Admission is free. The public is invited.

YOU'RE INVITED

to a complimentary Public Affairs Breakfast on Monday, April 6, 1981, 7:30 a.m., Boulevard Room at the Radisson Hotel, Chicago



Guest Speaker

The Hon. GEORGE H. RYAN (R.-43)

SPEAKER of the ILLINOIS

HOUSE OF REPRESENTATIVES

Tickets for the breakfast will be available at convention registration during the ISMS Annual Meeting on a first come, first served basis.

For further information, please contact Geoff Obrzut at ISMS offices, 55 East Monroe, Suite 3510, Chicago 60603. Telephone (312) 782-1654.

Leadership Conference

Competition Through Alternative Delivery Systems

9:30 a.m. to 12:30 p.m.
Monday, April 6
Radisson Chicago Hotel

The Choice Is Before Us—Regulation or Competition

Walter McClure, Ph.D.
Senior Vice-President, Policy Analysis
Interstudy
Minneapolis, Minnesota

What Is Competition?

In Delivery Systems
Gary Appel, Ph.D.
President
Council of Community Hospitals
Minneapolis, Minnesota

Ill. Rate Review Law
Martin Koldyke, Chairman
Michael Koetting, Acting Director
Ill. Health Finance Authority
Chicago, Illinois

Individual Practice Association

Dave Vogel, President
Dave Vogel & Associates
Management Consultants
Albuquerque, New Mexico

AMA Position On Alternative Delivery Systems

John J. Ring, M.D.
Vice Chairman
AMA Council on Medical Service
Mundelein, Illinois

A Panel Of Responders Who Are Aware Of How It Really Works

THE ILLINOIS EXPERIENCE

Jesse N. Frederick, M.D., Medical Director
Blackhawk Area Individual Practice Association
Rockford, Illinois

Robert P. Johnson, M.D., Vice President
Foundation for Medical Care of Central Illinois
Springfield, Illinois

Paul W. Moen, M.D., President
Western Illinois Independent Physicians' Association
Moline, Illinois

Substance Abuse: Clinical Aspects

Saturday, April 4, 1981 1:00-5:00 p.m.

Family Therapy: 1:00 p.m.

Linda Kyle-Spore, alcoholism counselor and family therapist, outpatient department, Institute of Psychiatry, Northwestern Memorial Hospital. A third year student in the Northwestern Center for Family Studies family therapists' program, Ms. Spore is associated with Lee Gladstone, M.D., director of the Institute's alcoholism treatment program. Family therapy to attack psychological isolation of the substance abuser will be demonstrated. In establishing alcohol and substance abuse as family problems, the presentation will approach the physician's role in providing support for family members, and examine the family dynamic.

Women and Alcohol: 2:00 p.m.

Edith S. Gomberg, Ph.D., School of Social Work, University of Michigan. A research scientist and faculty associate in the University of Michigan Institute of Gerontology and Institute for Social Research, Dr. Gomberg is a member of the editorial board for Focus On Women: Journal Of Addictions And Health. A member of the national advisory board for the 1979-80 Women in Crisis Conference, Dr. Gomberg is also on the Ad Hoc Substance Abuse Coordinating Committee of the Office of Substance Abuse, Michigan Department of Public Health and the Office of Health Services, Michigan Department of Mental Health. Dr. Gomberg will discuss the growing incidence of alcoholism among women, theories regarding its causes and special aspects of treatment.

The Impaired Physician: 3:00 p.m.

James W. West, M.D., chairman and founder of the ISMS Panel for the Impaired Physician, assistant professor of psychiatry, Rush-Presbyterian-St. Luke's Medical Center and director of alcoholism treatment services at Little Company of Mary Hospital in Chicago. Dr. West is medical director for the Central States Institute of Addictions and former chairman, Citizens Advisory Council on Alcoholism, IDMHDD. Programs to assist physicians impaired by dependence on alcohol and drugs, or physical and mental health problems which interfere with their ability to practice medicine, will be discussed. In addition, Dr. West will review recent trends in alcoholism treatment, including in-house hospital committees to assist medical staff members, and programs in other states.

Drug and Alcohol Abuse Update: 3:30 p.m.

Edward C. Senay, M.D., professor of psychiatry, University of Chicago Hospitals and Clinics, chief medical consultant, Illinois Dangerous Drugs Commission and chairman, ISMS Committee on Alcoholism and Drug Dependence. Dr. Senay has served as chief of the University of Chicago Psychiatric Consultation Service, director of the Illinois Drug Abuse Program and clinical director of Substance Abuse Services, Inc. Dr. Senay will present recent data on abuse of legal and illegal drugs as well as new knowledge in diagnosis and treatment of drug abusers.

Lee Gladstone, M.D., director, Alcoholism Treatment Program, Institute of Psychiatry, Northwestern Memorial Hospital. A member of the Illinois Department of Public Health Alcoholism Treatment Licensure Program Advisory Board and ISMS Committee on Alcoholism and Drug Dependence, Dr. Gladstone will discuss new approaches to diagnosis and treatment of the alcoholic patient.

AA Talks to Doctors: 4:00 p.m.

A representative of Alcoholics Anonymous will discuss what physicians can do to help alcohol abusing patients, and linkage with community service groups.

This program is presented in conjunction with the ISMS House of Delegates 1981 Annual Meeting at the Chicago Radisson Hotel, 505 N. Michigan Avenue. It is sponsored by the ISMS Committee on Alcoholism and Drug Dependence, with the support of a grant from the Illinois Department of Mental Health and Developmental Disabilities, Division of Alcoholism. The program is open to all members and there is no admission fee.

This seminar is accredited for four hours of Category 2 Continuing Medical Education credit for physicians. Application has been filed for Category 1 CME credit.

For further information, please contact the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago IL 60603; (312) 782-1654.

ISMS Auxiliary
Fifty-Third Annual Meeting
Radisson Chicago Hotel
Convention Program

Sunday, April 5, 1981

12:30 pm	Pin and Gavel Luncheon (Past Presidents Only) Mrs. R. Samuel Hoover, Hostess Honoring past state presidents and honorary members	*Alhambra Suite*
2:00-4:00 pm	Registration	*Tower "A"*
3:00 pm	Pre-Convention Board Meeting	*Tower Hall*
6:00 pm	Board of Directors Dinner	*Crystal Foyer*
8:00 pm	Reception honoring Members-At-Large	*Auxiliary Suite*

Monday, April 6, 1981

7:30 am	Public Affairs Breakfast	*Boulevard Room*
8:00 am	Registration AMA-ERF Boutique opens; coffee	*Tower A&B*
9:30 am	First Delegate Session Welcome Pledge to the Flag and Auxiliary Pledge Announcements Introduction of special guests Greetings from ISMS officers Memorial Service: *Mrs. Robert Reardon* Introduction of Keynote Speaker: *Mrs. Edward Szewczyk*	*Tower Hall*
10:30 am	**Keynote Address**—*Mrs. Harry S. Dvorsky,* President-Elect, AMA Auxiliary	
11:00 am	Guest Speaker—*John McAuliffe,* Centennial High School Student: **"Operation Snowball"**	
Noon	Social Hour	
12:30 pm	President's Luncheon Honoring past state presidents—guests invited Champaign County Auxiliary, hostesses Guest Speaker—*Dr. Sherry Manning,* president, Colorado Women's College: **"Becoming All That You Can Be"**	*San Juan-Kingston Rms.*
2:30 pm	Second Delegate Session	*Tower Hall*
3:30 pm	Workshop for officers and chairmen	
7:00 pm	ISMS President's Night	*Boulevard Room*

Tuesday, April 7, 1981

8:00 am	Registration AMA-ERF Boutique opens; coffee & rolls	
8:30 am	Get-Together for county presidents-elect and nominated presidents-elect	
9:30 am	Third Delegate Session County Reports County Awards Humanitarian Award Guest Speaker—*Dr. Domeena Renshaw,* Professor, Department of Psychiatry, Loyola University Medical Center: **"The Physician's Wife"**	*Tower Hall*
Noon	Social Hour	
12:30 pm	Installation Luncheon Kankakee County Auxiliary, hostesses Installation—*Mrs. Harold Keegan,* president New officers, directors and councilors Installing officer: *Mrs. Harry S. Dvorsky* Presentation of President's Pin & Gavel President's Acceptance speech: *Mrs. Harold Keegan* Program: **The Celebration Singers**	*King Arthur Room*
3:00 pm	Post-Convention Board Meeting	*Tower Hall*
8:00 pm	ISMS Theatre Party—"Evita"	

Schedule of Associated Meetings

Resident Physician Section

Saturday, April 4, 1981 **10:00-12:00 (n)**

Seminar: Loss Prevention Education

For registration information, please contact ISMS Headquarters. The RPS Annual Business Meeting and election of officers: 12:15 p.m.

Student Business Section

Saturday, April 4, 1981 **1:00-4:00 p.m.**

Seminar: Medicine 1990

For registration information, pleace contact ISMS Headquarters. The SBS Annual Business Meeting and election of officers: 4:00 p.m.

Saturday, April 4, 1981 **1:00-5:00 p.m.**

Seminar—Substance Abuse: Clinical Aspects

Sponsored by the ISMS Committee on Alcoholism and Drug Dependence, with the support of a grant from the Division of Alcoholism, IDMHDD.

Sunday, April 5, 1981 **11:15 a.m.**

Illinois Medical Political Action Committee Annual Meeting

Monday, April 6, 1981 **7:30 a.m.**

ISMS Public Affairs Breakfast

George Ryan (R) Kankakee
Speaker of the House
Illinois General Assembly

Tickets available at ISMS registration desk

Monday, April 6, 1981 **9:30 a.m.**

Leadership Conference: Competition Through Alternative Delivery Systems

Monday, April 6, 1981 **1:15 p.m.**

Illinois State Medical Inter-Insurance Exchange Annual Meeting of Members

Monday, April 6, 1981 **7:00 p.m.**

President's Night

IMPAC

ILLINOIS STATE MEDICAL SOCIETY
POLITICAL ACTION COMMITTEE
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

NONPARTISAN

NOTIFICATION OF ANNUAL IMPAC MEETING

The 1981 annual meeting of the Illinois State Medical Society Political Action Committee (IMPAC) will be held on Sunday, April 5, 1981, immediately following the adjournment of the ISMS House of Delegates:

APPROXIMATELY 11:15 A.M.
GRAND BALLROOM
RADISSON HOTEL
CHICAGO, ILLINOIS

All members of IMPAC are invited and encouraged to attend.

The 1981 IMPAC Nominating Committee has met and nominated the following individuals for membership on the IMPAC Council:

Terms Expiring 1984

Alfred Clementi, M.D.	Palatine
Louis Dondanville, M.D.	Moline
Edwin L. Falloon, M.D.	Evergreen Park
Morris T. Friedell, M.D.	Chicago
Don Hinderliter, M.D.	Rochelle
John W. Ovitz, M.D.	Sycamore
Albert W. Ray, M.D.	Joliet
P. John Seward, M.D.	Rockford
Herbert Sohn, M.D.	Skokie
A.E. Steer, M.D.	Springfield

Term Expiring 1983

Howard Burkhead, M.D. Evanston
(to fill the unexpired term of R.T. Fox, M.D., of Chicago)

P.F. Mahon MD

Paul F. Mahon, M.D.
Chairman, IMPAC

The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC. Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

Resolutions

1981 Annual Meeting

ISMS House of Delegates

The following resolutions were received at ISMS headquarters by February 1 and, according to provisions of the bylaws, are printed in *IMJ* by title and subject. Final deadline for resolutions was March 8. At this writing, it is anticipated that other resolutions will have been submitted for consideration before that deadline. These will be included in the Delegates' packet of materials.

Number:	*Introduced by:*	*Subject*
1 (A-81)	Michael R. Treister, M.D.	Manipulative Casting of Congenital Deformities of the Extremities
2 (A-81)	Donald W. Aaronson, M.D.	Prevention of Death From Anaphylactic Reactions to Stings by Stinging Insects
3 (A-81)	Joseph C. Sherrick, M.D., for the Board of Trustees	Deletion of Policy Manual Statement "Publication of Research Data"
4 (A-81)	Allan L. Goslin, M.D. for the Board of Trustees	Deletion of Policy Manual Statement on "Health Care—Ancillary Services"
5 (A-81)	Joseph C. Sherrick, M.D., for the Board of Trustees	Continuing and Modifying Policy Manual Statements Entitled "Journal Publication" & *"IMJ* Publication of Clinical Materials from ISMS-Sponsored Meetings"
6 (A-81)	Alfred J. Kiessel, M.D., for the Board of Trustees and the Council on Medical Services	Amendment to the Policy Manual Statement on "Immunization Programs"
7 (A-81)	Alfred J. Kiessel, M.D., for the Board of Trustees	Amendment to the Policy Manual Statement on "Drugs, Prescriptions"
8 (A-81)	Alfred J. Kiessel, M.D., for the Board of Trustees	Revision of Policy on Continuing Education
9 (A-81)	Alfred J. Kiessel, M.D., for the Board of Trustees	Deletion of Policy Manual Statement on "Constitution & Bylaws"
10 (A-81)	P. John Seward, M.D., for the Board of Trustees	Death With Dignity Legislation
11 (A-81)	Robert R. Hartman, M.D., for the Board of Trustees	Freedom of Choice Health Insurance Legislation
12 (A-81)	Alfred J. Kiessel, M.D., for the Board of Trustees	Definition of a Hospice Program
13 (A-81)	Kenneth E. Ambrose, M.D., for the Warren County Medical Society	Single Meeting of House of Delegates

CONVENTION '81

The 141st Annual Meeting
of the
Illinois State Medical Society
will be held at the
Radisson Hotel
505 N. Michigan Avenue
Chicago, Illinois
April 5-8, 1981

- **ISMS House of Delegates**
- **Gala President's Party**
- **Annual IMPAC Meeting**
- **Public Affairs Breakfast**
- **Theatre Party**

Further information about Convention may be obtained by contacting the Illinois State Medical Society, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603. Phone: (312) 782-1654.

PLAN NOW TO ATTEND CONVENTION '81

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DON'T FORGET—
Make Check or Money Order
Payable to Radisson Chicago Hotel
Do Not Send Currency.

ORGANIZATION _____
FUNCTION _____ DATES _____
All requests for the above group must be received by March 15, 1981

Please reserve accommodations for — Print or Type
NAME _____ (LAST / FIRST) COMPANY _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
SHARING ROOM WITH _____ NO. OF PERSONS _____
SIGNATURE _____

MONTH	DAY	YEAR

ARRIVAL DATE

ARRIVAL TIME

MONTH	DAY	YEAR

DEPARTURE DATE

CHECK IN TIME 3:00 PM
CHECK OUT TIME 1:00 PM

PLEASE CHECK PREFERRED ACCOMMODATIONS

ISMS/ISMSA ANNUAL CONFERENCE
April 3 - 8, 1981
SINGLE ROOM: $50 DOUBLE OR TWIN ROOM: $62
THIS CARD MUST BE RETURNED TO THE HOTEL BY MARCH 15, 1981 OR IT IS INVALID.

IF RATE REQUESTED IS NOT AVAILABLE, NEAREST AVAILABLE RATE WILL BE ASSIGNED. THERE IS AN ADDITIONAL $ 10.00 CHARGE FOR THE THIRD OR FOURTH OCCUPANT IN EACH ROOM. RATES ARE SUBJECT TO APPLICABLE TAXES. NO CHARGE FOR CHILDREN UNDER 18 OCCUPYING THE SAME ROOM AS PARENTS.

ACCOMMODATIONS WILL NOT BE CONFIRMED WITHOUT A CHECK FOR THE 1st NIGHT'S DEPOSIT OR USE YOUR AMEX OR DINERS CLUB CREDIT CARD # TO GUARANTEE YOUR RESERVATION. YOU WILL BE CHARGED FOR THE 1st NIGHT IF RESERVATIONS ARE NOT CANCELED 48 HOURS PRIOR TO ARRIVAL.

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Five Wednesdays In Family Practice

The Sixth Annual Family Practice Review Course

May 13, 20, 27, June 3, 10, 1981
Department of Family Practice
Rush-Presbyterian-St. Luke's Medical Center
Chicago, Illinois

Important aspects of clinical medicine to be reviewed include common problems of the child, the adolescent, the adult, and the older adult. There will be one full day on office problems and procedures. This course is acceptable for up to 30 hours of prescribed credit by AAFP and AMA Category I.

For more information contact Patricia Wilson, Rush-Presbyterian-St. Luke's Medical Center, Office of Continuing Education, 600 S. Paulina, Chicago, Illinois 60612. (312) 942-7095.

Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal*. The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order*: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal*. The *Journal*, however, will secure author permission before authorizing a reprint.

Student Business Section in Action

Conspiracy of Silence

This is the fourth of a five-part series on cigarette advertising.

Of all the evils of cigarette advertising, there are three in particular that stand out. First and most obvious is the role that it plays in increasing cigarette consumption. Cigarette ads may accomplish this by a combination of: (1) recruiting new smokers; (2) making it more difficult for smokers to quit; and (3) acting as an external cue to smoke, thereby increasing smokers' level of cigarette consumption. This effect should not be surprising in light of the themes used in cigarette advertising, which were discussed in last month's column.

A more subtle effect, pointed out by former Senator Maurine Neuberger, is that cigarette advertising "... affords the cigarette smoker a convenient rationalization for his addiction, for he is able to say to himself, 'If smoking were really dangerous, the government would surely put a halt to all that advertising'."

Perhaps the most insidious effect of cigarette advertising is its use by the tobacco industry to manipulate the media into a virtual silence on the health hazards of smoking. The industry accomplishes this by spending almost $900 million annually for cigarette advertising. Moreover, the advertising of diversified interests that tobacco companies have recently acquired—in the area of general consumer products—allow them to exert pressure not only in the print media (which is well documented), but presumably on television as well, where cigarette ads are banned.

One early example of the tobacco industry's pressure tactics was documented by Susan Wagner in her book CIGARETTE COUNTRY: TOBACCO IN AMERICAN HISTORY AND POLITICS. *Reader's Digest,* which does not accept cigarette advertisements and which has had an exemplary record of printing informative articles on the dangers of smoking, published one such article in its July, 1957, issue. Wagner's book pointed out that on July 17, 1957 a New York advertising agency abruptly terminated its contract with the *Digest,* a faithful client for the past 28 years. Unraveling the motivation for that action requires no detective work: the American Tobacco Company happened to be another prominent client of the agency, with annual advertising expenditures ($22 million) that towered over the Digest's paltry $1.25 million.

One may expect, though, that publications that accept cigarette ads, may experience tobacco industry pressure. The February 1980 newsletter of the American Council on Science and Health (ACSH), for instance, reported that a major tobacco company withdrew $18,000 of advertising from *Mother Jones* immediately after an April, 1978, article on health hazards of smoking. Undaunted, *MJ* printed a series of such articles in its Jan., 1979 issue. A *MJ* editor reported to ACSH that: "within two weeks . . . the two remaining tobacco companies cancelled their existing . . . contracts...."

Alan Blum, M.D., in his December, 1979, column in the *U.S. Journal of Drug and Alcohol Dependence,* related a similar incident involving a Canadian newspaper. In the midst of a series of articles in the *Ottawa Citizen* in June of 1979, encouraging readers to quit smoking, Imperial Tobacco, Ltd. cancelled one and a half months of advertising.

The threat of lost ad revenue may have prompted many publishers to censor or squash articles detailing the facts about smoking. The *New York Post* (1/5/79) reported how *US* Magazine killed one such story. Dr. Blum, in the column mentioned above, and Elizabeth Whelan, in *JAMA* (244:2045, 1980), have related their own experiences with censorship of articles on smoking. Further evidence comes from an article in the *New York Times* (2/19/78). It gave an account of how one paper prepared a story on smoking and cancer *only because* it didn't have cigarette advertising for the next issue.

One would predict from these anecdotal reports a sharp disparity in the amount of attention devoted to exposing the cigarette scandal between publications that do and do not accept cigarette advertising. And, in fact, this has been confirmed. In an article in the Jan./Feb. 1978 issue of the *Columbia Journalism Review,* R.C. Smith re-

ported the results of a seven-year survey of magazines' treatment of the smoking issue. "In magazines that accept cigarette advertising, I was unable to find a single article, in seven years of publication, that would have given readers any clear notion of the nature and extent of the medical and social havoc being wreaked by the cigarette smoking habit. The records of magazines that refuse cigarette ads, or that do not accept advertising at all, were considerably better." Particularly dismal performances were noted in the "women's service magazines." News magazines, were likewise found remiss.

This whole affair is perhaps best summed up, in the words of a spokesman for Action on Smoking and Health (ASH), as "the crassest case of journalistic prostitution one will ever see." The bottom line for health care providers is that, until this situation improves, we alone must bear the responsibility of educating the public on the hazards of smoking. Each and every one of us must renew and increase our efforts to educate our patients, *relentlessly*, until they quit smoking. ◀

Ronald M. Davis
Delegate, ISMS-SBS

This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Student Business Section.

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Board Abstracts

(Continued from page 145)

HOUSE OF DELEGATES RESOLUTIONS

At its recent meeting, the House of Delegates referred several resolutions to the Board for study and recommendation. Acting on those proposals, the Board voted to recommend that the House:

- *Adopt Res. 80I-16* which calls for revision of the ISMS policy statement on "Hospital Records and Their Availability." The Board concluded that the proposed policy accurately reflects legal restrictions on release of patient care records.
- *Reject Res. 80I-22* which directs ISMS to urge AMA to take steps that would enjoin the federal Health Care Financing Administration from enforcing a regulation which allows intermediaries to deny Medicare payment to physicians under investigation for questionable practice patterns as determined by PSRO review. Research revealed that the regulation cited in Res. 80I-22 actually referred to hospital payments. Specifically, it permits fiscal intermediaries to rebut the favorable waiver of liability presumption granted under PSRO in cases where the PSRO discovers an admission was ordered by a physician whose practice patterns have been found questionable. Any impact such denial may have on the physician's admitting privileges—as determined by the hospital—would not be affected by passage of the resolution.
- *Reject Res. 80I-27* which calls upon ISMS to support legislation to require use of full-face helmets when riding or driving a motorcycle. The Board noted that a 1969 Illinois helmet law was both repealed and declared unconstitutional. In related action, the Board voted to undertake activities to encourage helmet use.
- *Reject Sub. Res. 80I-29* which calls for the ISMS President to establish a task force to investigate new means to improve the retention and distribution of physicians in medically underserved areas of Illinois. The Board emphasized that ISMS cannot exert any influence over the chief factors involved with a physician's choice of practice location . . . and there is no common agreement as to what constitutes a shortage area. In related action, the Board voted to: (1) Authorize the ISMS Physician Recruitment Program to increase charges to communities seeking doctors so it can disseminate information on physicians listed with the AMA Placement Service; (2) Urge medical schools to develop residency programs in locations removed from metropolitan academic settings; and (3) Urge county medical societies to encourage development of Medical Education Community Orientation programs (MECO) and establish a system of maintaining contact with MECO participants after they complete that training.

The Board also voted to introduce resolutions urging the House to:

- Adopt a proposed policy on hospice programs which would define a hospice as ". . . a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either inpatient settings, home care or a combination of both. Bereavement counseling is provided for the survivors."
- Approve for introduction in the General Assembly a legislative proposal—formulated in response to Res. 80I-21—that would amend Illinois insurance laws and grant policyholders freedom-of-choice in structuring health insurance coverage.
- Permit ISMS to not actively oppose so-called "death with dignity" legislation if the proposal does not force the physician to comply with mandates of a "living will" and grants immunity from suit to those who honor the terms of a "living will."

LEGISLATION

The Board approved drafts of legislative proposals—for introduction in the current General Assembly session—that would:

- Modify "special damage" requirements and allow a wrongfully-sued individual to more easily bring legal action against the party who initiated an unwarranted suit.
- Restrict application of the Res Ipsa Loquitur doctrine—"the thing speaks for itself"—as a means of proving negligence in malpractice cases.
- Repeal—effective January 1, 1986—a state requirement that all female patients be given a PAP smear test, unless it is contraindicated or the patient underwent such a test within the past year.
- Provide state compensation to persons suffering injury because of a state-mandated vaccination program.

In other action concerning legislation, the Board voted to:

- Oppose legislation (HB 118) that would permit optometrists to use diagnostic drugs.
- Support legislation that would amend Illinois statutes to grant a permanent exemption from liability for illness induced by blood transfusions. If the General Assembly is unwilling to support a permanent exemption, ISMS will support a four-year extension of the current liability waiver.
- Seek legislation that would simplify and standardize procedures for complying with the state-mandated pre-marital serological test for syphilis. ISMS will recommend that a marriage license applicant be required to present only a certificate—signed by a physician—indicating that on the basis of a physical examination and serological test, he/she does not have infectious syphilis.
- Oppose any proposals designed to modify the Medical Practice Act to either: (1) Lower standards for acceptance of U.S. citizens who are graduates of foreign medical schools; or (2) Modify the criteria which must be met by medical schools to have their graduates accepted for education or licensure in Illinois. Reports indicate Illinois legislators are being pressured by some foreign schools—and parents of Illinois students attending them—to ease licensing requirements so that the students may secure clerkships and postgraduate positions in Illinois hospitals.
- Oppose legislation—developed by IDPH—that would allow three or more laymen to form a corporation and employ physicians, nurses and other health care personnel to treat patients. The proposal stipulates that such corporations must receive a registration certificate from R&E, and the IDPH director certify "that the applicant will receive federal . . . or similar state funds." The Board of Trustees noted that the proposal—apparently an attempt to obtain federal funds for the corporations under the Rural Health Initiative Program—would jeopardize the professional independence of health care providers.

CHANGES IN POLICY MANUAL

In accordance with House of Delegates' action, the Board approved the following policy statements for inclusion in the Policy Manual:

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Illinois Department of Registration and Education to the appropriate county society.

The Board will introduce resolutions at the House of Delegates' 1981 annual session urging the House to:

- Delete from the ISMS Policy Manual statements titled: "Publication of Research Data," "Health Care-Ancillary Services," and "Constitution and By-laws."
- Amend ISMS Policy Manual statements titled: "Immunization Program," "Drugs, Prescriptions" and "Continuing Education" . . . and combine and amend statements titled "Illinois Medical Journal" and "IMJ Publication of Clinical Materials from ISMS Sponsored Meetings."

SPECIAL PROGRAMS

Acting on requests concerning special programs, the Board voted to:

- Endorse the Illinois Continuity of Care Organization's 5th Annual Educational Seminar, May 12-13, in Champaign. The seminar is conducted for RNs involved in discharge planning or utilization review, social workers and administrative personnel.
- Approve ISMS sponsorship of an alcoholism education exhibit at the 1981 Illinois State Fair. Funding will be provided under a grant from the IDMHDD Division of Alcoholism which supports multi-faceted ISMS alcoholism education activities.
- Endorse and publicize an Illinois Cancer Council survey—planned for March—of 1,400 physicians to determine views on the benefits of tests and examinations aimed at early cancer detection and prevention, as well as what practices they follow regarding these tests. ISMS will request that the *Illinois Medical Journal* be given the opportunity—on a "first refusal basis"—to publish survey results.
- Approve scheduling a day-long seminar on the role of allied health professionals. The session will be similar to a program last October which allowed various professional groups to air views on the roles of allied personnel.
- Approve plans for a four-hour program on alcoholism during the ISMS annual meeting. Topics will include: family therapy in alcohol abuse; women and alcohol; the impaired physician; drug and alcohol abuse; and Alcoholics Anonymous talks to doctors.
- Endorse IDPH efforts—mandated by law—to establish a registry of persons exposed to DES (diethylstilbestrol) and conduct a public education campaign on the drug's hazards. The Board agreed to endorse the registry activity provided: (1) IDPH secures funds necessary to maintain an adequate registry; (2) ISMS is consulted regarding forms, use of data, and information generated; and (3) Research data is scientifically evaluated by a recognized M.D. clinical investigator. The ISMS Committee on Maternal Welfare was authorized to continue its review of informational materials and data collection activities involved with the IDPH program.

HEALTH PLANNING

The AMA will be urged to press for a delay in implementation of federal health planning regulations that would extend certificate-of-need (CON) requirements to equipment—even in physician offices—costing at least $150,000 and used to treat hospital inpatients. Illinois must align its CON law with federal statutes by December 8 or face a cutoff of public health funds from Washington. Under federal regulations, physicians must notify the State Health Planning and Development Agency (SHPDA) 30 days before buying, renting or leasing equipment that meets the cost mark, even if it is not intended for hospital inpatients. SHPDA then determines whether a CON is required. Failure to notify the State agency automatically subjects equipment to CON provisions. Illinois also must modify its CON law to cover any new institutional health service costing at least $75,000 annually. ISMS also will urge AMA to intensify efforts to have the CON regulation withdrawn.

LICENSURE/PHYSICIAN DISCIPLINE

The Society will urge Governor Thompson and the R&E Director to take appropriate steps to: (1) Eliminate delays—caused by CME audit activities—in renewing physician licenses, and also to speed processing of new licensure applications; and (2) Increase the efficiency of the State's medical disciplinary system. Some 466 complaints against physicians are pending, including 210 filed more than a year ago.

MEDICAL EDUCATION

ISMS will urge the Illinois Board of Higher Education (IBHE) to reconsider its master plan projections for medical school "entering-class" size, but recommend that the goal for primary care residency positions remain unchanged. IBHE's class-size plan called for 1,350 students in the fall of 1980, while actual size was 1,202. ISMS will urge revision of the plan noting that: (1) Previous enrollment projections may not be met because of insufficient school resources and facilities; (2) Requirements for numbers and kinds of physicians have changed since the census on which the plan in based; (3) Growing influence of family practice may reduce the number of physicians needed below estimates; and (4) The master plan is 10 years old and may not be valid under present circumstances.

ISMS will recommend continued adherence to the primary care residency goal because—according to IBHE's tables—the number of filled positions is consistent with projections and meets the goal of 50 percent of medical school enrollments.

IDPA DRUG MANUAL

The following drugs were approved for inclusion in the IDPA Drug Manual: Anaprox, Zomas (zomepirac sodium), Staticin (erythromycin), Meclomen (meclofenamate sodium), Voxin PG, Asendin, and Op-Site (dressing).

The Society will urge IDPA to issue a special supplemental list of drugs approved by ISMS for inclusion in the Drug Manual . . . and to resume distribution of quarterly supplements listing newly-approved products. Without the supplements, physicians and pharmacists are not aware of additions until a new manual is issued. In addition, ISMS will request that all references to generic drugs specify "approved quality generic . . ."

ENVIRONMENTAL POLLUTION

ISMS will urge the Illinois Section of the Environmental Protection Agency's Region V to appoint a medical advisory board that would study and make recommendations on methods of dealing with health risks associated with environmental pollution. Approximately one-quarter of the nation's hazardous wastes are disposed of in Region V—which includes Illinois. In addition, the EPA has indicated that Illinois is faced with special environmental problems caused by nuclear waste, hospital waste disposal, air pollution from coal mining and water pollution. Despite this situation, there is minimal input from the medical profession on the impact of these problems and EPA's regulatory efforts.

APPOINTMENTS/NOMINATIONS

The Board approved the following appointments to ISMS committees:

- *Dr. Allison Burdick, Jr.,* Oak Park—Judicial Panel, succeeding Dr. Howard Burkhead, who resigned. Under ISMS Bylaws, the Board is empowered to appoint a replacement—based upon nomination of the ISMS President—who will serve until the next House of Delegates meeting.
- *Drs. Pedro Poma,* Melrose Park; *Melvin Freedman,* Granite City; *John Froiland,* Chicago; *Boyd McCracken,* Greenville; and *Harold Zenisek,* Rockford—Committee on New Health Practitioners. Dr. Poma was named chairman of the newly-formed committee.
- *Dr. Robert Eilers,* Chicago—Resident Physicians Section representative on the Council on Medical Service.
- *Edward Staren,* Chicago—Student Business Section representative on the Governmental Affairs Council.

Nominated for appointment to state posts were:

- *Dr. Allan Levy,* Champaign—Medical Examining Committee of the Department of Registration & Education.
- *Dr. Theodore Polley,* Joliet—Drivers' License Advisory Board of the Illinois Department of Public Health.
- *Drs. John Holland,* Springfield; *Joseph Winterhalter,* Jacksonville; and *Alex Spacone* and *Joan Cummings,* both of Chicago—Emergency Medical Services Council of the Illinois Department of Public Health.

Acting as corporation members of ICCME, the ISMS Executive Committee elected the following as ISMS representatives to the ICCME Board of Directors: *Drs. E. Chester Bone,* Jacksonville; *Alfred Clementi,* Arlington Heights; *Kenneth Hurst,* Naperville; *William Lees,* Lincolnwood; *Donald Pochyly,* River Forest; *Robert Prentice,* Springfield; *Roger Wujek,* Litchfield; *Dean Bordeaux,* Peoria; and *Fred White,* Chillicothe. Upon nomination of their respective medical schools, the following were elected to the ICCME Board as representatives of those schools: *Drs. Michael Dykes,* Northwestern University Medical School; *Chase Kimball,* University of Chicago Pritzker School of Medicine; and *Harold Paul,* Rush Medical College . . . and *Ben Blivaiss,* Ph.D., Chicago Medical School; *Linda Gunzburger,* Ph.D., Loyola University Stritch School of Medicine; *Marten Kernis,* Ph.D., University of Illinois College of Medicine; *Charles Osborne,* Ed.D., Southern Illinois University School of Medicine; and *Ward Perrin,* D.O., Chicago College of Osteopathic Medicine. The ICCME Board has elected Dr. Pochyly as president, succeeding Dr. Lees. Dr. Bone was elected vice-president, and Dr. Wujek, treasurer. Dr. Hurst was re-elected secretary. ◀

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OBITUARIES

***Abrahamson, Victor,** Chicago, died January 15, 1981, at the age of 54. Dr. Abrahamson was a 1953 graduate of the Queens University Faculty of Medicine.

***Bahamonde, Jose Maria,** Jacksonville, died October 29, 1980, at the age of 61. Dr. Bahamonde was a 1945 graduate of Havana University.

***Burke, John Vincent,** McHenry, died January 16, 1981, at the age of 64. Dr. Burke was a 1941 graduate of the University of Illinois Medical School.

***DeMola, Antonio L.,** Grant Park, died January 4, 1981.

****Gorecki, Helen E.,** Chicago, died January 26, 1981, at the age of 85. Dr. Gorecki was a 1917 graduate of the Loyola University Stritch School of Medicine.

****Horner, Harry T.,** Chicago, died January 19, 1981, at the age of 78. Dr. Horner was a 1931 graduate of the Chicago Medical School.

****Johnson, Paul Thomas,** Fonatana, Wisconsin, formerly of Rockford, died January 31, 1981, at the age of 76. Dr. Johnson was a 1931 gradute of Rush Medical College.

***Keever, Ivan Charles,** Chicago, died January 15, 1981, at the age of 59. Dr. Keever was a 1952 graduate of the Case Western Reserve University.

***Schwerin, George S.,** Chicago, died January 27, 1981, at the age of 71. Dr. Schwerin was a 1941 graduate of the Chicago Medical School.

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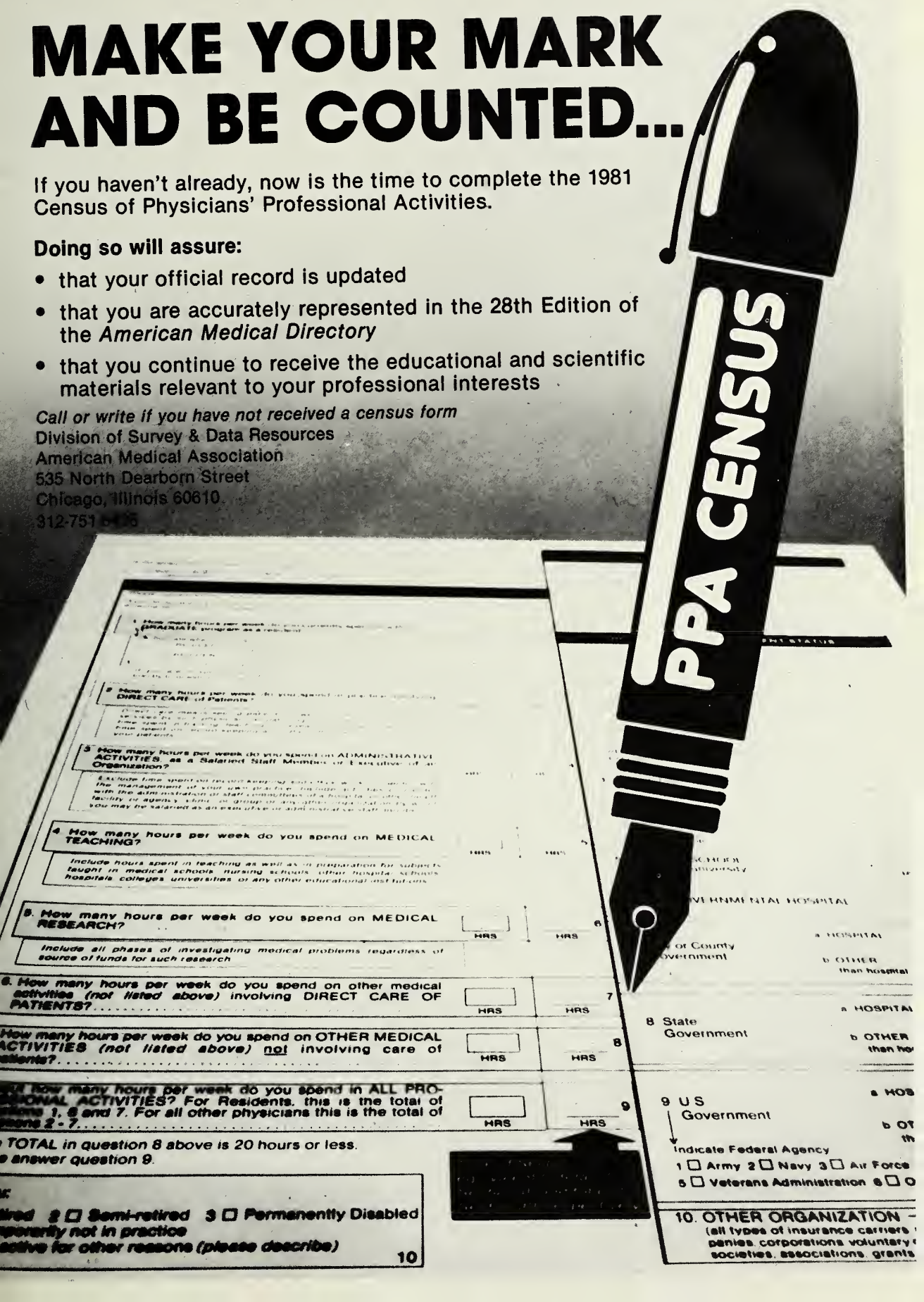
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Doctor's News

PHYSICIANS IN THE NEWS—Theodore Grevas, M.D., Rock Island, was elected chairman of the Illinois Delegation to the American Medical Association. The Delegation also elected **Howard Burkhead, M.D.,** Evanston, to serve as secretary.

Sanford Finkel, M.D., will become medical director at Barclay Hospital, Chicago **William U. McReynolds, M.D.,** Quincy, recently received a bronze plaque from the American Intraocular Implant Society, in recognition of his "McReynolds Lens Analyzer."

Newly elected officers of the Illinois Council on Continuing Medical Education are **Donald F. Pochyly, M.D., M.Ed.,** River Forest, president; **E. Chester Bone, M.D.,** Jacksonville, vice-president; **Kenneth A. Hurst, M.D.,** Naperville, secretary and **Roger A. Wujek, M.D.,** Litchfield, treasurer. The ICCME Corporate Membership (the ISMS Executive Committee) earlier had elected the 1981 ICCME Board, composed of the four officers above, immediate past president **William M. Lees, M.D., Ph.D.,** Lincolnwood, **Ben B. Blivaiss, Ph.D.,** Lincolnwood; **Dean Bordeaux, M.D., M.A.,** Peoria; **Alfred J. Clementi, M.D.,** Palatine; **Michael Dykes, M.D., M.Ed.,** Chicago; **Linda Gunzburger, Ph.D.,** Maywood; **Martin Kernis, Ph.D.,** Chicago; **Chase P. Kimball, M.D.,** Chicago; **Charles E. Osborne, Ed.D.,** Springfield; **Harold A. Paul, M.D., M.P.H.,** Chicago; **Ward E. Perrin, D.O.,** Chicago; **Robert Prentice, M.D.,** Springfield and **Fred Z. White, M.D., M.A.,** Peoria.

A SIGNIFICANT OMISSION—Doctors L.F. Layfer and J.V. Jones, contributing co-editors of the *IMJ Rheumatology Rounds,* have informed us of an error in the January issue. The column published that month on page 44 and entitled "Arthritis/Dermitis Syndrome—Part III," should have shown the author's byline. The article was written and edited by Scott Kale, M.D., of the department of medicine, section of rheumatology, Rush-Presbyterian-St. Luke's Medical Center. Our sincere apologies to Doctor Kale.

THE CHALLENGE OF THE OCCUPATION-RELATED LOW BACK PATIENT—The Illinois State Medical Society, with the Chicago Medical School's Department of Rehabilitation Medicine, is co-sponsoring an educational program for physicians on the prevention, diagnosis, and treatment of low-back syndromes. This interdisciplinary program will be held on April 29th, 1981, from 12:30 to 5:30 p.m. at the Ambassador West Hotel, 1300 North State Parkway, Chicago. Five hours of Category 1 Continuing Medical Education credit will be offered.

Presentations will include: "The Radiologic Confirmation," by Dr. Walid Hindo; "The Premorbid and Postmorbid Aspects," by Dr. Marshall A. Falk; "The Rehabilitation Approach, Evaluation and Treatment," by Dr. Eugene Rogers: "The Orthopedic Surgical Approach," by Dr. Peter Altner.

A special feature of the program will be an introductory talk on "The Adjudicator's Problems with the occupation-related low back patient," by James A. Thomas, Esq., an attorney representing the Illinois Industrial Commission. Mr. Thomas' talk will attempt to provide the medical community with the knowledge and expertise needed to contend with workmen's compensation cases.

SUBSTANCE ABUSE WORKSHOP ANNOUNCED—The Illinois Dangerous Drugs Commission, in conjunction with Lutheran General Hospital's Department of Psychiatry and Alcoholism Treatment Center, will present a special one-day workshop for physicians on the clinical management of alcoholism and drug dependence on Tuesday, May 5, 1981, at Lutheran General's Walter E. Olson Auditorium, 1775 Dempster Street, Park Ridge. Entitled "Multiple Substance Abuse Workshop for Health Care Workers (Physicians)," the session will address a wide spectrum of clinical and practical case management issues. The program has been accredited for five hours of Category 1 CME credit for physicians, and the $15 registration fee includes workshop materials and lunch. Advance registration is required. Further information is available through Mr. Joseph DiFiore, Illinois Dangerous Drugs Commission, 300 N. State St., Suite 1500, Chicago 60610: (312) 822-9860.

Viewbox

(Continued from page 140)

DIAGNOSES: 1. Non-ossifying fibroma 2. Fibrosarcoma 3. Osteosarcoma 4. Aneurysmal bone cyst.

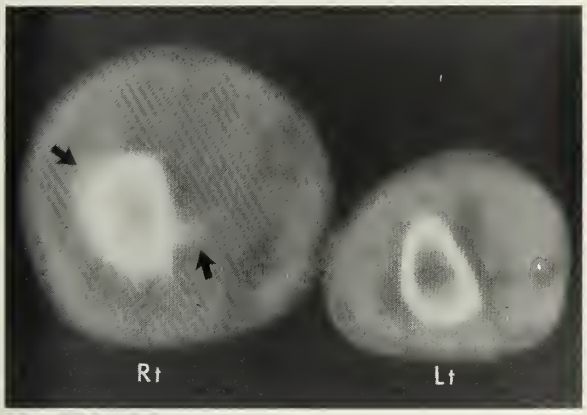


Figure 5
Computed tomography—osteosarcoma of the right femur. There is extensive periosteal bone formation (arrows), a large soft tissue mass, and obliteration of the marrow cavity —compare to the normal left femur.

"The pathologist responsible for the diagnosis of osseous lesions handicaps himself immeasurably if he ignores their roentgenographic features. Although roentgenographic shadows do not supplant microscopic sections in the final diagnosis, they frequently afford practically conclusive evidence of the malignant or benign nature of bony lesions and often indicate the histologic type." This quotation is from a book analyzing over 6,000 bone tumors authored by the bone pathologist, David Dahlin.[1]

The importance of radiographs in the diagnosis of solitary bone lesions is or ought to be well known. How should radiographs of bone lesions be evaluated? A gestalt approach to radiographs has been termed the "Aunt Minnie" or aircraft recognition method of diagnosis—an approach roughly similar to picking a criminal out of a po-

(Continued on page 202)

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Viewbox

(Continued from page 201)

lice lineup. This method works if "classic" textbook lesions are seen, but in many cases lesions are not typical and instant recognition must give way to thoughtful analysis in order to avoid serious errors.[2]

Facets to be considered in evaluating a solitary bone lesion include:[2,3] (1) Patient age; (2) Location of lesion; (3) Margination of lesion; (4) Periosteal new bone formation; (5) Tumor new bone formation and (6) Soft tissue mass.

The four patients presented here emphasize the importance of observing the margin of a bone lesion which causes a solitary "geographic" area of bone destruction. The character of the margin provides evidence concerning the growth rate of the lesion.

Sharp Margin—Sclerotic Rim

These lesions are slow growing. The edge of the lesion is sharply defined and there is said to be a narrow zone of transition between the lesion and normal bone. The thin sclerotic rim indicates that the lesion is replacing normal bone slowly enough to allow the normal bone to form sclerotic reactive bone (Fig. 1). Most of these lesions are benign.

Sharp Margin—No Sclerotic Rim

These lesions are growing at a slow rate but not slow enough to allow adjacent normal bone to form reactive bone. The entire circumference of the lesion must be inspected since loss of definition of a segment of the margin indicates rapid growth at that point. In Figure 2 the superior margin of the fibrosarcoma is definable but not the inferior margin. In addition the anterior cortex of the femur is destroyed.

Unsharp Margin

These lesions are growing so rapidly that the edge of the lesion is difficult to identify. There is a wide zone of transition between the lesion and normal bone (Fig. 2, 3). If the lesion is aggressive enough it becomes difficult or impossible to identify where the lesion ends and where normal bone begins. Many malignant bone tumors are rapidly growing.

Expansile

Some lesions cause resorption of the inner or endosteal surface of the cortex slowly enough to

allow maintenance of the outer cortical surface by periosteal new bone formation. The end result is an "expanded" appearance (Fig. 4). Both malignant and benign tumors can have an expanded appearance.

Many malignant bone tumors exhibit features of rapid growth so that poor margination should always suggest the possibility of malignancy Non-neoplastic processes such as osteomyelitis also may advance rapidly so that poor margination is not equated with malignancy. In addition malignant tumors may grow slowly. No radiographic sign is pathognomonic of a benign or malignant lesion. In any one patient with a solitary bone lesion *all* radiographic and clinical findings must be considered. If the diagnosis remains in doubt, tissue must be obtained and the histology correlated with radiographic and clinical findings.

While computed tomography is not often of value in making the primary diagnosis of a bone malignancy in the extremities (compared to plain radiographs), it does provide clear depiction of tumors of the spine and pelvis in patients in whom plain radiographs are normal or demonstrate only subtle abnormalities. In the extremities C.T. is valuable in demonstrating the extent of a bone tumor for therapy planning. The soft tissue mass of the tumor is clearly shown and can assist in deciding on en bloc resection versus amputation in selected neoplasms (Fig. 5). C.T. is superior to angiography in evaluating most patients for therapy and can identify the relationship of the tumor to major vessels following intravenous injection of contrast media.[4,5]

References

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5. DeSantos, L.A., Bernardino, M.E., Murray, J.A.: "Computed Tomography in the Evaluation of Osteosarcoma," *AJR* (1979) 132:535.

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KANSAS CITY, MISSOURI—Emergency Department Physicians—American Medical Services Association, Inc., a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are: (1) Board Eligible or Certified; (2) Show an affinity for the team concept of medical practice; (3) Business oriented; (4) Show professional maturity and judgment; (5) Have a keen desire to succeed; (6) Committed to CME. We are successful because we offer the unique package of salary and benefits in the health care industry. All of our physicians participate in the ownership of the company. If you feel qualified we are interested in you. Contact: Michael P. Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc., 4400 Broadway—Suite 306, Kansas City, Missouri 64111; (816) 931-3040.

FAMILY PRACTICE—available immediately in fully equipped office with a busy practice. 18 miles from Champaign, Ill. Great location for family. Phone (217—832-8283).

ALLERGIST—ABAI certified/eligible via medicine or pediatrics wanted for one or two days per week in west suburban allergy practice. Contact Box 986 c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

ASSOCIATE WANTED to join 2 board certified family practitioners in Arlington Hts., Ill. Must be board eligible or certified. Start July, 1981. Send C.V. with first reply. Contact Box 987 c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

FORT WAYNE, INDIANA—Emergency Department Physicians—American Medical Services Association, Inc., a Kansas City based multiple hospital physician group, is seeking career oriented primary care and emergency care physicians who are: (1) Board Eligible or Certified; (2) Show an affinity for the team concept of medical practice; (3) Business oriented; (4) Show professional maturity and judgment; (5) Have a keen desire to succeed; (6) Committed to CME. We are successful because we offer the unique package of salary and benefits in the health care industry. All of our physicians participate in the ownership of the company. If you feel qualified we are interested in you. Contact: Michael P. Colucci, Vice-President of Marketing and Recruitment, American Medical Services Association, Inc., 4400 Broadway—Suite 306, Kansas City, Missouri 64111; (816) 931-3040.

PHYSICIAN—Gastroenterologist, $57,500/Yr - 60 hours/week. Practice in a modern medical clinic. Completion of recognized internship, licensability and highly acceptable references required. Contact: David Bennett, Clinic Manager, Sterling Rock Falls Clinic, 101 E. Miller Road, Sterling, IL 61081.

GRIDLEY: Long established family practice for sale, rent or lease. Terms negotiable. Excellent schools, churches, and hospitals. Contact J. Wesley Helm, M.D. Gridley, Il 61744 (309) 747-2083.

IMJ Attention

AMA UPDATES NATIONAL NEWS — Proposed national budget cuts include a recommendation to phase out health planning over the next two years and a reduction in that area of $75 million over the next fiscal year. An Office of Management and Budget (OMB) team was quoted a stating that "this policy action would be consistent with a two-year Administration timetable for development and implementation of a pro-competitive bill for health financing reforms.

The OMB report also recommends that Medicaid payments be cut back, leading to a limit on payment increases by the federal goverment to an inflation index by 1982. Also, they suggest elimination of Public Health Service hospitals and also all new scholarships under the National Health Service Corps. The report calls for a reduction of monies granted for health maintenance organizations and professional standards review organizations.

Each of these recommendations, as well as others affecting health care, will be subject to legislative review and approval.

The administration is also considering recommendations from the Congressional Budget Office (CBO) which include reduction in federal percentage of Medicaid payments by eliminating the 50% minimum share granted some states and giving more flexibility to state authorities in setting Medicaid reimbursement rates. The CBO report also calls for incentives to hospital cost containment programs and closure of Public Health Service Hospitals. They would eliminate federal Medicaid benefits for SSI recipients and revise tax deduction provisions regarding health insurance premiums and medical expense deductions. Finally, the CBO would tax employer health insurance plans and limit tax-exempt hospital bond issues.

Any administrative recommendations which grow out of these proposals will be subject to legislative review and approval.

TWO ILLINOIS MEMBERS OF THE HOUSE OF REPRESENTATIVES will join House subcommittees related to health care. Representative Philip Crane will join the House Ways and Means Committee Health Subcommittee and Representative Edward Madigan has been appointed to the House Energy and Commerce Subcommittee on Health and the Environment.

HUMAN SUBJECT RESEARCH RULES REVISED — A new Federal ruling, which will take effect in June, will exempt five categories of human research from local review board consent as a criterion for federal funding. In each category, anonymity is required for subjects. The newly exempted areas are (1) educational research; (2) research on educational testing; (3) research using publicly available data/documents; (4) research on public behavior and (5) research using surveys or interviews.

VOLUNTARY EFFORT CITES FURTHER SUCCESS — The AMA Center for Health Services Research and Development has reported that, during the 12 month period from December 1979 through December 1980, physician fees increased 11%. The consumer price index for that period rose by 12.4% in the all-categories component and 14.2% in the all services component. The Voluntary Effort has urged that physicians continue cost containment efforts, calling for maintenance of total staffed beds at or below the 1980 level and limitation in growth of full-time equivalent employees per 100 daily patient census below the 1980 level.

A LETTER OF INQUIRY regarding concerns about Illinois Department of Registration and Education activities in medical licensure and discipline was sent to Governor Thompson. The correspondence, written at the direction of the ISMS Board of Trustees, asks the Governor to look into apparent inefficiencies.

The letter was prompted, in part, by complaints from ISMS members, and subsequent study of 1980 license renewal listings from the Department. It appears that many physicians for whom the Department computer shows a "non-renewed" status are not aware of this. Many of these physicians have received wallet cards, or their cancelled checks — or no indication whatever from the Department either way — which causes them to believe that their licenses have been renewed as usual. Others received a letter — which did not comply with Administrative Procedures Act requirements — stating that their licenses were "non-renewed." Many physicians have telephoned and written the Department, and been assured that their license status had been corrected — but no verification has been extended.

The letter to the Governor also asks for investigation of delays in processing cases intended for review by the Medical Disciplinary Board and stresses the importance of a fair and efficient means to curb abuses by persons requiring discipline.

REMINDER TO PRESCRIBERS — The use of prescription blanks with a pre-printed "X" in the "may not substitute" box is illegal. Illinois law requires that the check box and signature line be personally marked and signed by the physician; any variance automatically permits drug substitution. A check in the "may not substitute," box and signature on the "may subsitute" line will also permit substitution.

MENTAL HEALTH PROGRAM ANNOUNCED — The Illinois Hospital Association and Illinois Psychiatric Society will co-sponsor a program entitled "A Survival Guide for the 80s: A Future for Mental Health Care," on April 16, 1981, at the Chicago Drake Hotel. Intended to provide a forecast of mental health trends at the state and national levels, the program will include panels on mental health law, planning, finances and legislation. Further information may be obtained by calling (312) 325-9040, extension 29 or (217) 789-7272

GOV. JAMES THOMPSON has authorized a $9.5 million annualized increase in Medicaid payments for physician services beginning March 1. The increase — negotiated by ISMS — originally was to have taken effect Jan. 1, 1981. Delay in its implementation was the result of the Governor's order freezing hiring and new expenditures due to the state's economic condition.

PSYCHIATRIC CARE STUDY COMPLETED — A new study by the Illinois Psychiatric Society, performed in conjunction with the Illinois Association of General Hospital Psychiatry and conducted by Alex J. Spadoni, M.D., Joliet, provides data on psychiatric treatment in the private sector throughout Illinois. The following highlights are included in that report (all pertain to 1979 Illinois data): (1) about 70% of psychiatric inpatient care took place in the private sector; (2) the 2,945 private psychiatric beds in Illinois included 2,168 in general hospitals and 777 in private sanitaria; (3) a "dramatic increase in patients treated in the private sector, with a corresponding decrease in patients treated in state hospitals," was found to have occurred since 1970; (4) total psychiatric patient days had increased by over 100%, from about 400,000 to over 800,000, between 1970 and 1979; (5) average length of stay data was found to vary markedly between and within HSAs. The report will be published in total in the IPS *Examiner;* individual copies are available through the Illinois Psychiatric Society; (312) 263-7391.

Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

PROGRAM REDUCES RETROACTIVE CLAIMS DENIALS, SHORTENS HOSPITAL STAYS, SAVES MONEY

A Blue Cross and Blue Shield program designed to reduce retroactive claims denials for psychiatric hospitalizations is producing substantial savings as well.

Richard C. Shaw, M.D., the Plan's medical director, said a recent evaluation of the Concurrent Psychiatric Review Program, shows that it has:

— Virtually eliminated retroactive denial of psychiatric claims from hospitals in the program.

— Shortened the average length of psychiatric hospital stay by 10.46 days in cases studied.

— Produced a documented annualized savings of $1.27 million on the cases studied.

"These documented results are part of the story," Dr. Shaw continued.

The study covered only extended stays for the six most common diagnoses for cases treated at nine participating Chicago area hospitals during 1979. The program, which began in mid-1978, now is operating in 12 hospitals.

He said the dollar savings were calculated by comparing average length of stay under the new concurrent review program with average length of stay under the previous retroactive review system.

Under retroactive review, Dr. Shaw explained, psychiatric cases were often not reviewed by the insurer until the patient was discharged from the hospital. "In some cases the patient faced responsibility for sizeable hospital bills," he said.

"In concurrent review, Blue Cross and Blue Shield and the participating hospitals were advised of our review guidelines, developed in cooperation with the psychiatric community," Dr. Shaw noted. He lauded the participating hospitals and physicians for their contributons to the success of the program.

He outlined the program as follows:

"When a psychiatric patient is admitted to a participating hospital, a contact person at the hospital notifies the psychiatric nurse reviewer at Blue Cross and Blue Shield within 72 hours of admission. If the reviewer determines that the level of care is within the guidelines and covered by the patient's contract, payment is approved for up to 15 days.

"If the medical records show that the patient is not receiving a covered level of care, the psychiatric nurse reviewer refers the case immediately to a Blue Cross and Blue Shield consulting psychiatrist. The psychiatrist either approves payment for the care for up to 15 days, or establishes a probable future payment cutoff date. The contact person at the hospital is immediately advised, in either case. This review process is repeated at intervals throughout the hospitalization.

"This process provides advance indication of coverage status so that planning for discharge or alternate care can be accomplished in a timely fashion.

"In practice, the program has exceeded all expectations," Dr. Shaw said. "There has been excellent cooperation from participating psychiatrists."

General Motors Retiree Identification Cards

With the implementation of the General Motors Retiree program on October 1, 1980, all retired GM members were issued gold identification cards which contained their group and social security numbers. Since this card does not identify the member's home plan by name, but only by *plan code* (e.g. 210), it is important that this plan code appear on every claim. We cannot correctly process these claims without this code. The plan code is easily located in the bottom right corner of each gold identification card.

ILLINOIS BLUE CROSS AND BLUE SHIELD PLAN EXPANDS SECOND OPINION SURGERY PROGRAM

The Illinois Blue Cross and Blue Shield Plan is expanding the availability of its Additional Second Opinion Program to virtually all of its members.

The program pays for a second surgical opinion on whether recommended elective surgery is necessary.

Richard C. Shaw, M.D., the Plan's vice president and medical director, said "the program is designed to reduce health care costs by curtailing unnecessary surgery.

"Approximately 30 percent of all hospital admissions are for elective surgery — operations which are non-emergency," Dr. Shaw explained. "If there is a non-surgical, medical treatment for the problem that would be more appropriate, there is a potential substantial savings through the reduction of unnecessary surgery."

Dr. Shaw said "We began the program as a pilot project in 1977 with approximately 20,000 subscribers and broadened it to include 250,000 members during the next few years. However, because of the limited participation, use of the program has not been high enough to obtain accurate cost savings estimates.

"We are confident the program has sufficient potential to warrant making it available to most of our members," Dr. Shaw explained. "This broadening should also give us a better reading on cost savings."

The Additional Surgical Opinion Program is being offered on an optional basis to all groups of more than 22 employees as their contracts come up for renewal during the year. The program has been added as a standard benefit for some 75,000 small group and non-group members under 65 years of age. Individuals over 65 years of age have a second opinion program available through Medicare.

Under the program, a patient whose physician has recommended surgery can call a special Blue Cross and Blue Shield referral service number (312/661-4908). A trained counsellor provides the member with the names of three qualified surgeons in the member's geographical area. Blue Cross and Blue Shield benefits pay the cost of the second opinion, including x-rays and other tests required by the consulting surgeon.

The consulting surgeon, Dr. Shaw explained, agrees not to perform the surgery or treat the patient for the condition under consideration.

If the two surgical opinions do not agree, the program pays the cost of a third opinion. The decision on whether or not to have the operation is up to the patient, and does not affect Blue Cross and Blue Shield benefits in any way.

EXPERIMENTAL SECOND OPINION PROGRAM STARTED FOR STEEL WORKERS

United States Steel and Bethlehem Steel companies have included a voluntary second surgical opinion program for employees and their dependents on an experimental basis.

The program, which will be in effect through July 31, 1983, will operate as follows:

— A second surgical opinion will be considered a covered benefit only for the following elective surgical procedures — hysterectomy, tonsillectomy and adenoidectomy, cataract surgery, spinal and vertebral surgery, prostate surgery, cholecystectomy, mastectomy and excision of cysts, tumors or lesions from the breast.

— If one of these procedures is recommended, the opinion of a second physician will be covered. In the event the two surgical opinions differ, the program pays for the cost of a third opinion. Also covered are any necessary laboratory tests and/or x-rays performed in connection with the consultation.

Note: The purpose of the second surgical opinion is purely advisory. Benefits will not be predicated upon the employee or dependent following the advice of any of the physicians consulted.

— In submitting claims, physicians giving second and/or third opinions should file the Blue Shield Physician Service Report forms indicating the following: diagnosis; consultation fee and laboratory tests and/or x-rays performed and the fee for each. The statement "Steel Second and/or Third Surgical Opinion" should be entered in the PSR's "Description of Services" section. Failure to include this language could result in the denial of the claim.

GM Retirees — Illinois Plan Members

All retired GM members with coverage through the Illinois Plan have Blue Cross only contracts. This means that physician and professional services including prescription drugs should be submitted through the Metropolitan Life Insurance Company, the GM carrier for professional claims, and if the member is eligible, to the Medicare Part B carrier.

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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

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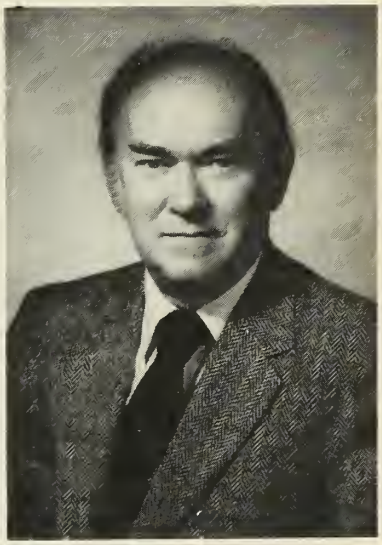
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President's Page

Competition Redefined



Clearly government is changing course. All signals indicate that there is a dual trend toward pro-competition and deregulation activities. Philosophically, and conceptually, this pincer attack on our nation's economic problems is consonant with the thinking of many physicians and the major policies of organized medicine.

However, we must recognize that so abrupt a change in direction will require significant rethinking of our values and priorities. After several decades of developing policies and implementing strategies to resist governmental incursions into the practice of medicine, to block or modify federal and state regulatory efforts and to diminish outside controls on our practices, we may now find that we are well prepared to confront an enemy who has vanished.

Perhaps we will witness the end of competition with HSAs over the need for services and number of hospital beds . . . with PSROs over the length of patients' hospital stays . . . and with federally-funded HMOs.

The gradual elimination of medicine's competition with government most likely will be replaced by competition within medicine: competition among individual physicians or practice groups. Physicians who have known only a "sellers market" may be forced to practice in a new environment.

As it was important for us to learn the implications and the jargon of regulatory activities, it becomes equally essential that we now learn of the implications of "a free market system," the jargon of competition, and what this competitive approach could or might do to our practice of medicine, to us individually and to our medical society.

In the past or passing situation, we became informed and then developed positions and strategies that were appropriate and effective. It is now equally important to become informed, enabling us to make intelligent choices once again.

We must consider what competition means when applied to the practice of medicine. We must learn how competition can occur and at which levels so that quality and the ethical practice of medicine will not be compromised. Above all we must be sure that our patients will not receive less care, either in quality or amount, than they truly require.

Competition—almost by definition—suggests that someone will get more for less. Again, we must be sure that our patients do not get less. ◀



Fred Z. White, M.D., President

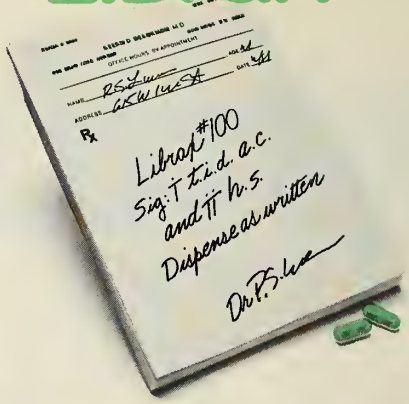
Clinics for Crippled Children Listed for May

Thirty-nine clinics for Illinois' physically handicapped children have been scheduled for May by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 9 cardiac clinics, one for children with neurological problems and one for myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

1 Division Cardiac—U. of I. at the Medical Center
4 Peoria Myelodysplasia—St. Francis Medical Center
5 Belleville—St. Elizabeth's Hospital
5 Park Ridge Cardiac—AM—Lutheran General Hospital
5 Park Ridge General—PM—Lutheran General Hospital
5 Wheaton General—Marianjoy Rehab. Hosp.
6 Rock Island CP—Foundation for Crippled Children and Adults
6 Hinsdale—Hinsdale Sanitarium
7 Effingham—St. Anthony Memorial Hospital
7 Sterling—Community General Hospital
7 Pittsfield—Illini Community Hospital
7 Lake County Cardiac—Victory Mem. Hosp.
11 Peoria Cardiac—St. Francis Med. Center
11 Chicago Heights Cardiac—St. James Hosp.
11 Maywood—(Orth/Ped/Neuro)—Loyola Medical Center
12 East St. Louis—Community Hospital
12 Peoria—St. Francis Medical Center
13 Mt. Vernon—Good Samaritan Hospital
13 Champaign-Urbana—McKinley Health Serv. Center
13 Chicago Heights General—St. James Hosp.
13 Joliet—St. Joseph Hospital
14 Kankakee General—St. Mary's Hospital
14 Aurora Cardiac—Mercy Center for Health Care Services
14 Springfield General—St. John's Hospital
14 Macomb—McDonough Health Department
15 Kankakee Cardiac—St. Mary's Hospital
18 Chicago Heights Cardiac—St. James Hosp.
18 Maywood—(Ortho/Ped)—Loyola Medical Center
19 Rock Island Area General—Moline Public Hospital
19 Alton—Alton Memorial Hospital
19 Decatur—Decatur Memorial Hospital
20 Springfield Ped-Neuro—St. John's Hospital
20 Evergreen Park—Little Company of Mary Hospital
21 Rockford—Rockford Memorial Hospital
21 Centralia—St. Mary's Hospital
21 Elmhurst Cardiac—Memorial Hospital of DuPage County
26 Peoria—St. Francis Medical Center
27 Chicago Heights General—St. James Hosp.
27 Elgin General—Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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Final classification of the less-than-effective indications requires further investigation.

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***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

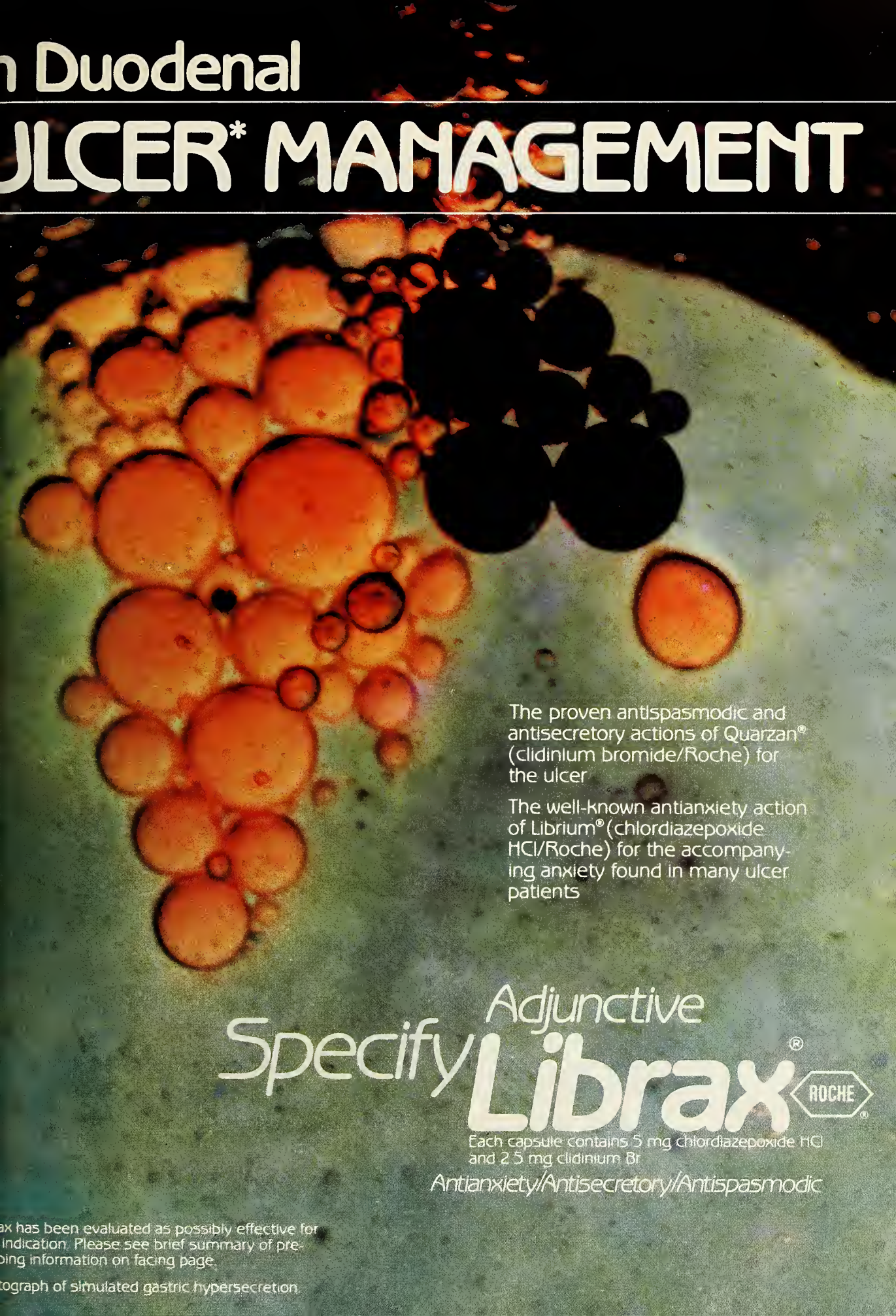
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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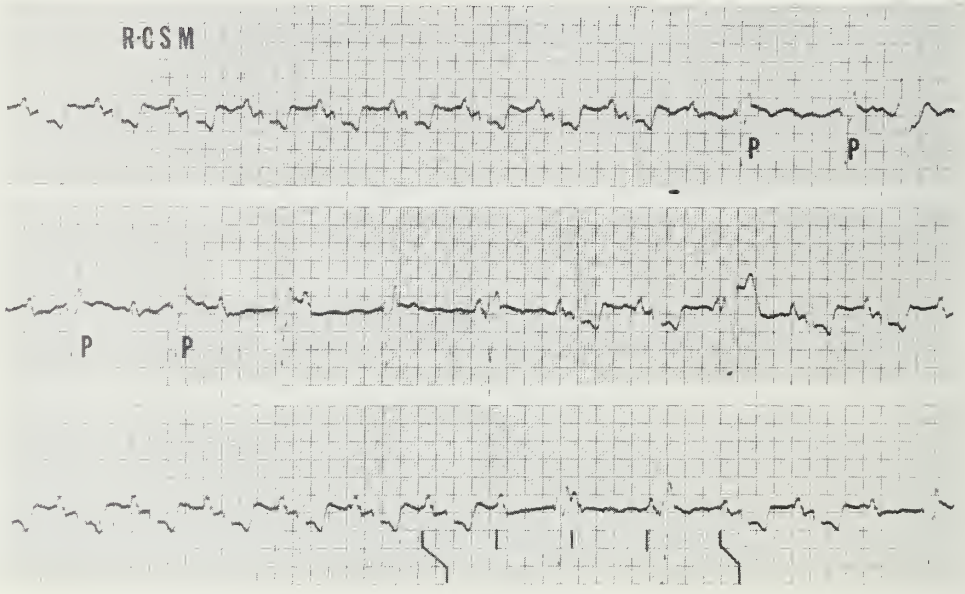
ax has been evaluated as possibly effective for indication. Please see brief summary of pre- oing information on facing page.

tograph of simulated gastric hypersecretion.

EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., Dovid J. Hole, M.D., Patrick J. Sconlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., ond Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a fifty-seven year old man who presented to the emergency service with complaints of palpitations and lightheadedness. He had a double aortocoronary bypass and left ventricular aneurysmectomy four years earlier. Physical exam of the heart demonstrated a heart rate of 140 beats per minute and a ventricular gallop (S_3). He also had bilateral fine crepitant rales in the lungs. His blood pressure was 90/40mmHg. An ECG showed atrial flutter with 2:1 atrioventricular (AV) block and complete left bundle branch block. Direct current cardioversion restored sinus rhythm but long R-R cycles developed. A temporary transvenous pacemaker was placed in the right ventricular apex. The patient was admitted to coronary care to rule out a myocardial infarction. The next day right carotid sinus massage (R-CSM) was carefully performed to evaluate the pacemaker function.



Questions:

1. **The ECG continuous rhythm strip in the top and middle panels shows:**
 - A. Sinus slowing.
 - B. An occasional premature ventricular beat.
 - C. A well functioning demand pacemaker (P).
 - D. The carotid sinus massage-induced AV block.
 - E. All of the above.

2. **The lower ECG strip was taken several hours later and shows:**
 - A. Sinus rhythm with second degree AV block.
 - B. Well functioning demand pacemaker.
 - C. Evidence for an acute myocardial infarction.
 - D. Ventricular tachycardia.
 - E. The return of complete left bundle branch block.

(Continued on page 247)

IMPAC

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The person who says that he is above politics is really saying that democracy is beneath him.

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The contribution supports a political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere thraugh AMPAC. Contributions are not ilmited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor ar disadvantage anyone based upon the amounts of or failure to make PAC contributions. Copies of IMPAC and AMPAC reports are filed with and are available for purchase from the Federal Election Commission, Washington, D.C. Contributions are subject to the limitations af FEC regulations, Sections 110.1, 110.2, and 110.5 (Federal regulations require this notice). IMPAC reports are also filed with the State Baard af Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois 62704.

OBITUARIES

***Bock, Harold L.,** Normal, died February 12, 1981, at the age of 61. He was a 1943 graduate of the University of Illinois College of Medicine.

***Cunningham, Raymond J.,** Palos Hills, died March 8, 1981, at the age of 44. Dr. Cunningham was a 1965 graduate of the Chicago College of Osteopathic Medicine.

****Frisch, Isaac J.,** Chicago, died February 22, 1981, at the age of 90. He was a 1912 graduate of Chicago College of Medicine and Surgery.



***Lees, William M.,** Lincolnwood, died March 28, 1981, at the age of 66. A board certified general and thoracic surgeon and fellow of the American College of Surgeons, Dr. Lees was a member and immediate past president of the ICCME Board. He served as chairman of the ISMS Board of Trustees from 1972-74, and as a member of that body, 1965-77. The 1977-78 ISMS second vice president, Dr. Lees was a member or chairman of several ISMS councils and committees. Dr. Lees had been chief of staff at Hines VA Hospital, a professor of cardiopulmonary surgery for the Loyola University Stritch School of Medicine and chief of surgery at the Municipal Tuberculosis Sanitarium in Chicago.

****McBean, Myrtle Jean,** Duarte, CA, formerly of Oak Park, died October 20, 1980, at the age of 81. She was a 1925 graduate of the University of Manitoba Faculty of Medicine, Winnipeg.

****Meyer, Joseph L.,** Chicago, died March 3, 1981, at the age of 82. Dr. Meyer was a 1923 graduate of Loyola University Stritch School of Medicine.

***Thegze, Charles G.,** Chicago, died February 27, 1981, at the age of 67. He was a 1939 graduate of a medical school in Budapest, Hungary.

****Rosenblum, Abraham I.,** Chicago, died March 3, 1981, at the age of 78. Dr. Rosenblum was a 1927 graduate of the University of Illinois College of Medicine.

***Rubinstein, Richard I.,** Chicago, died March 11, 1981, at the age of 51. Dr. Rubinstein was a 1955 graduate of the University of Chicago Pritzker School of Medicine.

****Wanderer, A.E.A.,** Oak Park, died March 11, 1981, at the age of 89. Dr. Wanderer was a 1912 graduate of the University of Illinois College of Medicine.

* Indicates ISMS member
**Indicates ISMS member of the fifty year club

Brief Summary

INDICATIONS — For management of anxiety disorders or short-term relief of symptoms of anxiety. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use (over 4 months) not assessed by systematic clinical studies. Physician should periodically reassess usefulness for each patient.

For symptomatic relief of acute alcohol withdrawal.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 18. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

DOSAGE — ANXIETY — Usual daily dose 30 mg or less (start the elderly or debilitated at 7.5-15 mg). Adjust gradually within 15-60 mg daily range. Capsules and scored tablets: divided doses; or once daily h.s. (start patient at 15 mg). Single dose tablets, 22.5 mg (for patients stabilized on 7.5 mg t.i.d.) or 11.25 mg: once daily at any hour.

INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE — Take general measures as for any CNS depressant.

SUPPLIED — Tranxene (clorazepate dipotassium) 3.75, 7.5, and 15 mg capsules and scored tablets. Tranxene-SD Half Strength 11.25 and Tranxene-SD 22.5 mg single dose tablets.

REFERENCES — 1. The elimination kinetics of an agent can be closely defined, but cannot at present be directly related to therapeutic or adverse effects. 2. Sedation reported in normal volunteers 30 minutes after dosing. TRANXENE Drug Monograph 97-0185, 1979, p. 9. 3. Op cit., p 15.

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How therapy for anxiety stops is as important as how it starts.

When treatment with TRANXENE® *concludes*, nordiazepam levels taper gently.[1] This built-in tapering effect may give patients time to adjust to post-therapy — an important consideration when choosing an agent for short-term management of anxiety.

Yet, TRANXENE *starts* fast. Pharmacologic effects are observed in just half an hour.[2] Peak serum levels are reached in 1-2 hours.

TRANXENE offers predictable calming action.[3] In 25 short-term studies, positive therapeutic response ranging from 83% to 90% was obtained. TRANXENE. A logical first choice for short-term therapy.

Tranxene® IV

clorazepate dipotassium

Starts promptly... stops gently

See opposite page for brief summary.

The Viewbox

Contributing Editor Terrence Demos, M.D., ossociote professor of rodiology,
Deportment of Rodiology, Loyola University Stritch Schoo! of Medicine

This month's Viewbox was contributed by Richard Provus, M.D., fellow in Nuclear Medicine, Loyola Univ. Med. Ctr., Maywood

This 69-year-old white male with a known history of severe chronic lung disease was admitted through the emergency room with a complaint of upper abdominal pain. The patient was receiving steroids for his lung disease.

The physical examination of the abdomen revealed right upper quadrant pain without rebound. The patient's temperature was 36.5 C. The white count at the time of admission was 12,900. The serum amylase was normal. Clinically, acute cholecystitis was suspected.



Figure 1
Supine Abdomen

Your Diagnosis?

1. Acute Cholecystitis
2. Perforated Peptic Ulcer
3. Mesenteric Thrombosis
4. Abdominal Abscess
5. Acute Pancreatitis

What Would You Order Next?

A. IVC
B. Ultrasound
C. ^{99m}Tc-IDA Study
D. Oral Cholecystogram
E. Computed Tomography

(Continued on page 250)

Guest Editorial

M. E. C. O.

BY RICHARD C. LUSSKY, CHICAGO

Illinois MECO Project Director 1980-81

MECO (Medical Education Community Orientation) is a jointly sponsored ISMA Student Business Section/AMSA program for first and second year medical students. The program offers the student early clinical exposure and introduces him/her to the practice of medicine in a community orientation. MECO, depending on the state, is either a hospital centered program, (as in Illinois) a physician based program (as in North Dakota) or a combination of these two approaches (as in Kentucky).

In the hospital orientation, MECO is developed around the concept of mini-clerkships; the student rotates through hospital departments (*e.g.* surgery, pediatrics, medicine). Examples of opportunities are the ability to make rounds with physicians, assist in the OR or delivery room, and do histories and physicals.

When centered around individual physicians, the student gains pre-clinical experience on a one-to-one basis with a practicing physician during the daily management of his practice. With this approach, the student will have the same opportunities as those students in hospital based programs, but their participation will be centered around the physician's area of practice. Ideally, all three approaches will be additionally punctuated by the student's involvement in community programs (*e.g.* participation in nursing homes, drug rehabilitation centers, planned parenthood organizations, ambulance services). MECO basically offers the student a clinical orientation that is not available within the traditional medical curriculum.

MECO was founded in 1968 at Illinois Masonic Hospital in Chicago. Today, more than 4,000 students in 35 states have participated.

The goals and objectives of MECO are multifaceted. By introducing students early in their medical education to primary care medicine in a community atmosphere, and to the cultural, economic and environmental determinants of health, it is hoped that it will raise their awareness of the grave need for physicians in underserved areas and the increasing demand in general for quality, community oriented, primary care medicine. Additional goals of MECO are the following:

- To introduce the student to the operation and organization of community health care institutions and their inter-relationships and planning as related to the delivery of health care in a community.
- To introduce the student to the roles of other health care professionals and the interplay between these individuals and their fellow physicians.
- To introduce the preclinical medical student to the clinical aspects of medicine as a reinforcement and motivational force in relation to the medical school curriculum.
- To provide the student with an opportunity to take part in the planning of his own educational experience as a preparation for a lifetime of self-directed continuing education.
- To introduce the student to the multiple opportunities for continuing medical education in a nonacademic setting.

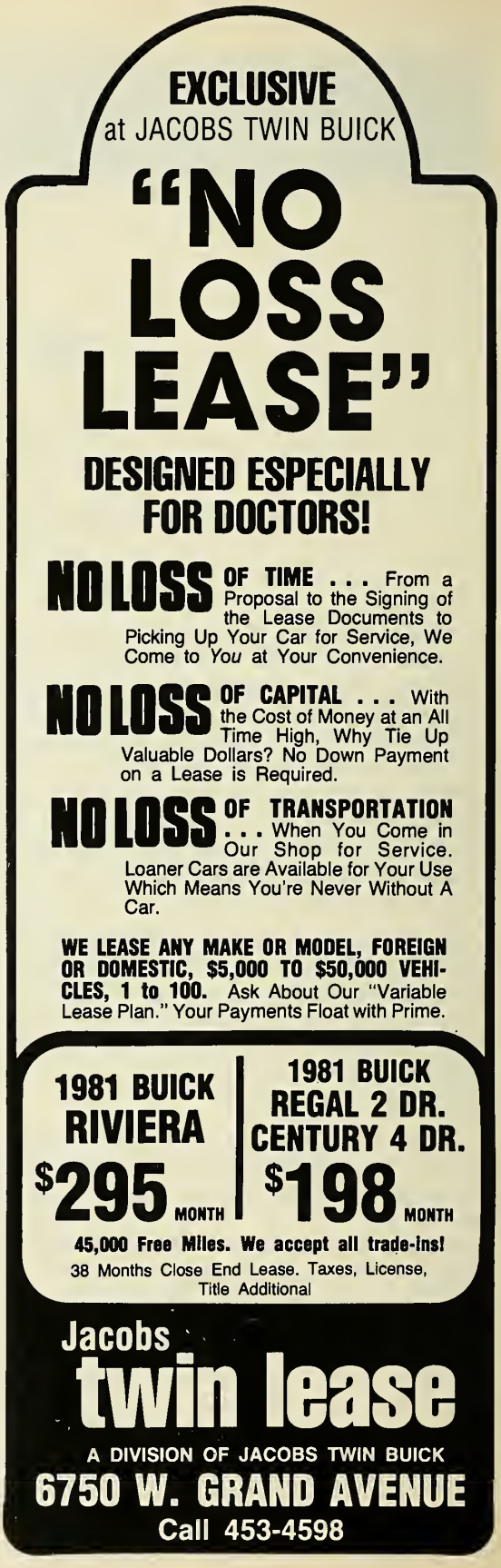
MECO also affords numerous advantages to the local community and participating hospital and/or physician(s).

- *A future increase in primary care physicians for the community.* Short term studies have shown a statistically significant number of students reported either returning or stating they will return to the locale of their MECO program.
- *An opportunity to be part of the educational system.* For many physicians a major appeal of the program is the satisfaction gained through participation in the medical education of future physicians and the stimulation provided by the student's presence.
- *Physicians receive continuing education credit for their participation from the Academy of Family Physicians and the American Medical Association.* The American Academy of Family Physicians grants thirty hours of continuing education credit to any members participating for a summer in the MECO program. The American Medical Association provides hour-for-hour credit towards its Physician Recognition Award, up to a maximum of 45 hours, for physicians of any specialty who teach students in the MECO program. Information related to reporting these credits may be obtained directly from the AAFP and the AMA.

ISMS/SBS is always searching for additional hospitals and physicians wishing to participate in the MECO program. Community hospitals that are not primary university teaching hospitals, community physicians and group practice clinics are ideally suited.

In general, students receive an educational stipend of at least $100 per week, plus room and board. This funding usually is provided by either the hospital where the student is based or by the physician preceptor, if an individual program is developed along the lines of a traditional preceptorship. In addition, funding in a number of communities has been obtained from local civic organizations (*e.g.,* Kiwanis, Rotary Clubs) local industry or private foundations responsive to the needs of a local or statewide area.

MECO in Illinois is co-sponsored by the Illinois State Medical Society's Student Business Section, the Illinois Hospital Association, the Illinois Academy of Family Physicians and the American Medical Student Association. For further information on MECO, please contact the ISMS Headquarters office, 55 East Monroe, Suite 3510, Chicago, Illinois 60603. ◀



IMJ
Illinois Medical Journal
Volume 159, No. 4, April 1981

In Acute Cervical Hyperextension-Hyperflexion Injuries

Transcutaneous Electrical Neurostimulation

By Robert R. Richardson, M.D. And Edir B. Siqueira, M:D./Chicago

Transcutaneous electrical neurostimulation (TENS) is a noninvasive modality that has been proven effective in treatment of various etiologies of acute and chronic pain, as well as prevention and treatment of post-traumatic and chronic neurogenic ileus. We have applied this modality as an ancillary therapeutic aid in 24 patients suffering "whiplash" injuries. Significant pain relief was achieved in 18 of 24 patients (75%).

Transcutaneous electrical neurostimulation (TENS) which evolved as a noninvasive alternative to dorsal column stimulation[1-3] has been successfully used in the treatment and alleviation of chronic intractable pain,[1-3] acute postoperative pain,[4] postoperative and post-traumatic ileus,[4-5] delivery pain,[6] peripheral vascular insufficiency,[7] and musculoskeletal pain of acute spinal cord injuries.[8] A most difficult type of pain to treat is the pain resulting from acute hyperextension-hyperflexion injury of the cervical spine, or the so-called "whiplash injury."[9-13] Definitive medical treatment in the vast majority of these injuries is conservative, although various psychosomatic and "litigation" elements can intercede and hinder effective medical treatment.[11,13] We applied TENS in alleviating the acute pain and muscular spasm of patients suffering from acute cervical hyperextension-hyperflexion strain or "whiplash injury" (Figure 1).

ROBERT R. RICHARDSON, M.D., is a board eligible neurosurgeon affiliated with Mount Sinai Hospital and Medical Center in Chicago. At this writing, Dr. Richardson was an instructor in neuroanatomy at the Northwestern University Medical School. He has also served as assistant chief of the Center for Physiologic Neurosurgery, and an assistant professor of neurosurgery at New York Medical College and New York University.

EDIR B. SIQUEIRA, M.D., is a board certified associate professor of neurosurgery at Northwestern University Medical School. He is a member of the medical staff for Northwestern Children's Memorial Hospital, Wesley Memorial Hospital and Cook County Hospital in Chicago. Dr. Siqueira is a former president, councilor and secretary-treasurer for the Chicago Neurological Society.

Materials and Methods

The Avery® alternate-pulse, constant-current transcutaneous electrical neurostimulation system with varying parameters of frequency, output, and pulse duration was utilized in the conventional manner.[14] The site of application was paracervical (Figure 2), and constant neurostimulation was used along with other conservative modes of therapy.

All 24 patients had been in automobile accidents and suffered traumatic hyperextension-hyperflexion injuries of the cervical spine or

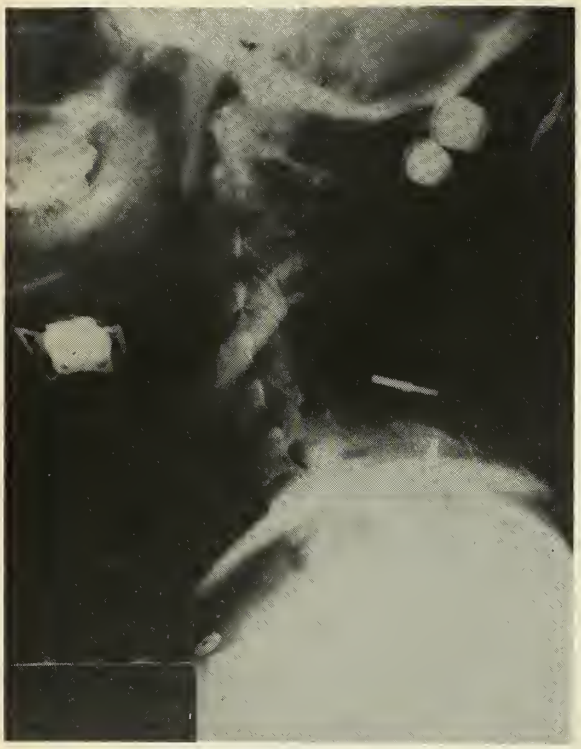


Figure 1
Lateral cervical roentgenogram showing "straightening of the cervical spine" postinjury of Case 4 (inpatient) wearing cervical brace.



Figure 2
Lateral cervical roentgenogram showing the paracervical placement of the Avery™ transcutaneous electrodes with their connecting stainless steel wires running to an external transmitter (not shown) in Case 4 (inpatient).

acute musculoskeletal strain between 1975-1977. All patients had complained of nonradicular, localized cervical pain and muscle spasms. Eighteen patients had associated occipital, bifrontal, chest, leg, shoulder or lumbo-sacral pain. All patients were neurologically intact, except for mild pain and limitation of neck and/or back motion. All had cervical roentgenograms negative for fracture and dislocation, but some showed reversal of the normal lordotic curvature (Figure 1). Ten of the 24 patients were treated (emergency room) and followed (outpatient clinic). Fourteen of the 24 patients were admitted and treated as inpatients. The patients were randomly selected, based on physician availability.

Quantitative and percentage methods were utilized to evaluate individually each patient's pain relief.[14] These values were based on the decrease or discontinuance of narcotic analgesics, improvement in motor and physical activities, a lessening of pain behavior and complaints, and increase in social communication and interrelationships. Significant pain relief was considered to be 50% or greater relief; insignificant pain relief was less than 50% relief. Complete pain relief was 100% relief and meant that the patient was on no narcotic analgesic, was ambulatory, and was interacting appropriately with no pain behavior. These values were computed and averaged by the involved physicians and nurses (Tables 1 and 2).

Results

After the initial application of the electrodes either on an outpatient or an inpatient basis, significant initial pain relief was achieved in 21 of 24 patients, (87.5%) consisting of nine outpatients and 12 inpatients. Nine out of the 12 inpatients and nine of the 10 outpatients continued to achieve similar significant pain relief one-to-two weeks postapplication of TENS (Tables 1 and 2). None of the 18 TENS-responders (75%) required any narcotic medication, and none remained on a constant or fixed intake of muscle relaxants and/or non-narcotic analgesics two weeks postapplication. The electronic parameters effective in achieving significant pain relief in the TENS-responding patients were as follows: *Output:* varying from 5 to 7; *Frequency:* varying from 4 to 6; *Pulse Duration:* varying from 4 to 5.

All six of the non-TENS responders had a legal suit in progress by two weeks postinjury, as opposed to only two patients out of the 18 TENS-responding patients. Three inpatients in the non-TENS responding group initially experienced

ACUTE CERVICAL HYPEREXTENSION—HYPERFLEXION OUTPATIENT INJURIES
Northwestern Memorial Hospital
Northwestern University
1975 - 1977

No	Patient	Days of TENS	Percentage Pain Relief with TENS	Medication Required	Legal Suit in Progress	Associated Problems
1	C M	5	100	Darvon 65 q 4 hours	No	Leg cramps
2	M H	15	100	Occasional aspirin	Yes	Headaches, vertigo
3	J C	—	0	Tylenol #3 q 4 hours Valium 5mg q.i.d	Yes	Low back pain, hostility, and anxious
4	T S	7	100	None	No	—
5	C P	6	50	Valium 5mg, q i.d Darvocet N, q 4 hours Occasional Tylenol #3	Yes	Low back pain
6	I V	7	100	Valium 5mg t i d	No	Bifrontal and occipital pain
7	G H	4	75	Darvocet N q 4 hours	No	—
8	I J	4	50	Darvon 65 q 4 hours	No	Headache
9	J D	6	75	Occasional Darvocet N	No	Thoracic and lumbar pain
10	I A	6	100	None	No	Headache, vertigo

Table 1

good pain relief, but this failed to last more than 24 hours.

Discussion

Acute cervical hyperextension-hyperflexion injuries (whiplash injuries) were initially described in 50 patients by Gay and Abbott in 1953.[10] Experimental studies later showed that the biophysical mechanism of the hyperextension injury was due to an acceleration force.[13] Pathophysiologically, minor "whiplash injuries" are caused acutely by rupture or stretching of the supporting nuchal ligaments, tears in the joint capsule, hemorrhage and edema into the paracervical musculature, and damage to the cervical sympathetic system.[9-13] Approximately 90% of these injuries are mild in that patients presented with localized, nonradicular nuchal findings and had no fracture and/or dislocation of the cervical roentgenological studies.[9-13] They are estimated to occur in 15% of all automobile accidents and are more prone to occur in women,[10,12,13] These mild cervical injuries were found to be associated with transient vertigo, mild concussion, transient vasomotor complaints, frontal and occipital pain and headache, and low back pain.[9-13] Later when a "litigation neurosis" or other psychosomatic elements were discovered in the course of the recovery or convalescent period, Gotten showed that 88% of these patients recovered completely.[11]

Various authors have prescribed varying conservative medical regimens for the treatment of

Dial Settings	Output Current (mA.) (Amplitude)	Pulse Width (uses.) ± 15%	Pulse Rate (pps)
0	0.2 ± 10%	72.5	8.7 ± 10%
1	0.3 "	100	9.5 "
2	0.55 "	150	10.5 "
3	1.0 "	190	12.0 ± 10%
4	2.6 "	235	14.5 ± 15%
5	5.5 "	280	18.0 ± 20%
6	11.0 "	330	25.0 ± 25%
7	16.0 "	360	36.0 "
8	26.5 "	400	90.0 ± 25%
9	38.5 ± 20%	440	240 ± 15%

Table 2

the acute phase of these minor, localized injuries.[9,10,12,13] Briefly, these include bed rest, limitation of activity, immobilization with a soft cervical collar, narcotic and non-narcotic analgesics, muscle relaxants, tranquilizers, injection of local analgesics, diathermy and physical therapy.[9,10,12,13] But all authors have stressed the importance of positive, aggressive treatment in the acute phase of this injury to prevent or lessen the development of the psychosomatic elements or "litigation neurosis" during the later convalescent state.[9-13]

The pathophysiological mechanism of action of TENS is the "blocking" or suppression of acute and chronic peripheral pain, based upon the Gate Control Theory.[15] Cook has stated that increases in the peripheral blood flow were due electrophysiologically to antidromic stimulation of C fibers in the dorsal roots, or the production of an "electronic" sympathetic inhibition.[5,7,8] This effect could explain the absence of sympathetic vasomotor symptoms and signs in the TENS-responding group.

The major advantages of using transcutaneous electrical neurostimulation included ease of application and the avoidance of all narcotic medications in the TENS-responding patients, except for occasional dosages of Tylenol #3® by three patients. While no major complications occurred, minor complications included occasional technical problems and hypersensitivity to the applied tape.

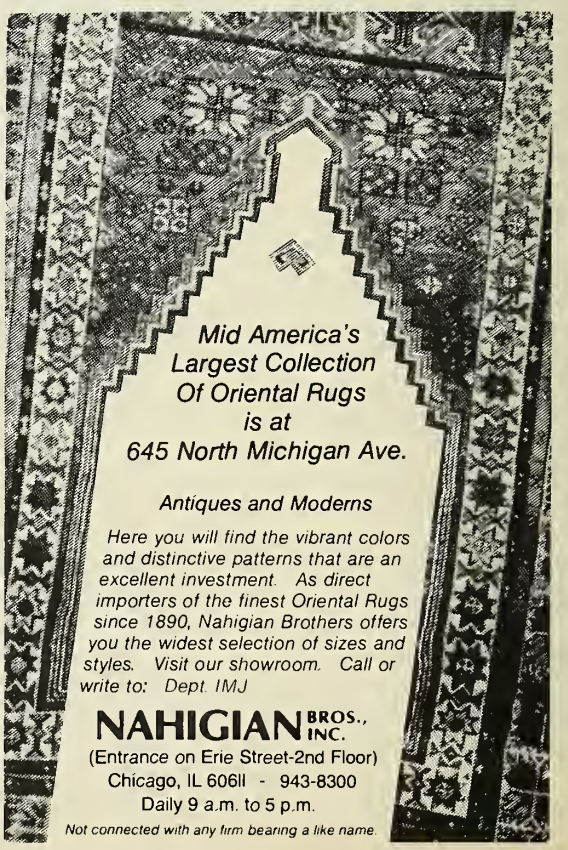
The effective use of transcutaneous electrical neurostimulation in alleviating pain, discomfort and muscle spasm in minor, acute hyperextension-hyperflexion injuries of the cervical spine ("whiplash injury") can be applied to both outpatients and inpatients as an ancillary therapeutic aid. Its potential role as a diagnostic indicator of patients prone to develop "litigation neurosis" has not been fully explored. ◀

Acknowledgements

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Seminars in Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

Environmental Factors, Genetics and Cancer

By Sandra R. Wolman, M.D./New York

The newspapers remind us almost daily of danger from carcinogens in our environment, whether from asbestos in hair dryers, radiation from a Three Mile Island accident, or chemicals in the Love Canal. We are tempted to think that if we could control such dangers in the environment we would be able to protect ourselves from cancer.

Yet these exogenous forces must react with a substrate, presumably genetic, which will be altered and can transmit the alteration. The genetic substrate, which is highly variable from one individual to the next, acts as a screen permitting some reactions and preventing others, protecting some individuals and not others. In some individuals or families there are strong hereditary determinants influencing the development of cancer with little evidence of environmental effects. The gastro-intestinal cancers arising in individuals with familial polyposis appear with regularity in the second to fourth decade of life, apparently regardless of environmental influences.[1] In contrast, the unusual tumors (angiosarcomas of the liver) seen after exposure to vinyl chloride, are clearly linked to that exposure.[2] One need not think of hereditary and environmental factors as opposing etiologies, but should consider that etiologic agents such as chemical carcinogens, radiation, or viruses, must interact with the host genome in order that the resulting phenotype of a malignant tumor be initiated.

The assumption that cancer at the cellular level is marked by genetic alterations is central to this. Individual tumors, even when they retain differentiated characteristics which permit identification of the tissue of origin, show extensive sets of morphologic and behavioral changes which enable us to recognize them as tumors. Mutations of many genes may determine these phenotypic alterations. It has been recognized for many years that most, although not all, human cancers contain chromosomal changes.[3]

These visible genetic alterations comprise large mutations which can affect cellular genetic information in several ways. Chromosome rearrangements can activate or repress specific genes; losses or gains in whole chromosomes or sets of chromosomes can alter gene dosage effects of many cellular functions. Both kinds of changes may affect cell replication and cell division. Some

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kinds of chromosomal changes appear to be specific to certain human tumors; the Philadelphia chromosome, actually a 9:22 translocation,[4,5] marks the cells of chronic myelogenous leukemia; rearrangement of a #14 is characteristic of many lymphomas;[6] loss of a #22 is seen in meningiomas.[7] Recently the loss of a very small region (band) on a #13 has been associated with occurrence of retinoblastoma,[8] a tumor whose patterns of inheritance have provided evidence in favor of a multi-step origin of human malignancy.[9] Consistent patterns of chromosomal aberration appear to be emerging for many malignancies of hematopoietic tissues.[10] In other, solid tumors, the inaccessibility of dividing cells and the extent of the chromosomal alterations have interferred with identification of tumor-specific abnormalities. However, with the development of methods for cloning and growth in tissue culture of human tumor stem cells, the ability to make such specific correlations should increase dramatically.[11,12]

It is generally assumed that most human tumors originate in a single cell. Both chromosomal and single-gene-determined biochemical markers have been used to demonstrate clonality in tumors. When chronic myelogenous leukemia evolves to a blastic (more malignant) phase other chromosomal aberrations are added to the Philadelphia-chromosome-bearing tumor cell.[13] The X-chromosomal location of the gene for glucose-6-phosphate dehydrogenase (an enzyme whose A and B forms can be identified cytologically) and the normal, random inactivation of the second X chromosome in females, have been combined to form a powerful tool for investigation. The heterozygous female has tissues composed of a mix of individual cells which express either the A or B form, but tumors from such individuals show only a single form of the enzyme in all cells.[14] Recently, demonstration of a single form of the enzyme in hematopoietic cells has served to illustrate that a stem leukemic cell can generate erythroid and thrombocytic as well as myeloid progeny.[15] Clear evidence of inheritance of markers from cell to cell and the uniform expression of a marker by all cells of a tumor point strongly to a single cell of origin, and indicate that the origin is associated with permanent, *i.e.*, genetic, alterations.

Genetics and Cancer

If we return from the cellular to a different (larger) perspective on the relationship between genetics and cancer, we can look at the influence of inherited factors on the incidence of cancer in human populations. At one end of the scale are observations of weak association between inherited factors such as blood groups or HLA types and specific tumors. Blood group A has been linked to a higher incidence of gastric cancers[16] and certain tumors are reported to appear more frequently in individuals with these haplotypes—AW24: germ cell tumors[17] and BW46: nasopharyngeal cancer.[18]

In contrast are the more powerful associations, exemplified by the gene-determined dominant forms of intestinal polyposis and consequent colonic malignancies. The range of genetic effects includes many types of gene-determined but non-cancerous disorders which appear to predispose to development of malignant tumors; possibly by altering rates of tissue proliferation, immune response, or DNA synthesis or repair. The sporadic occurrence of systemic chromosomal aneuploidy also appears to influence the development of tumors in the afflicted individuals (leukemia is almost 50-fold more frequent in Down's Syndrome, trisomy 21, than in age-matched controls, and males with Klinefelters Syndrome, 47,XXY, are approximately 20 times more likely to develop breast cancer than are normal males).[19,20]

Although the number of well-defined, clearly inherited cancers is small, they appear to share certain characteristics which may be useful in distinguishing other tumor syndromes in which the influence of hereditary factors is more subtle. In the cases of polyposis, multiple endocrine adenomatosis, or bilateral retinoblastoma, the tumors are usually inherited in an autosomal dominant pattern, appear relatively early in life, and are frequently multiple. Familial aggregates of site-specific tumors are often seen, most commonly with breast cancer and adenocarcinomas of the gastro-intestinal and genito-urinary tissues. These, too, show dominant transmission, early onset and increased incidence of more than one primary site. "Cancer families" are now identified on the basis of similar patterns of appearance[21] and it seems likely that there are hereditary and non-hereditary forms of most of the common human tumors.

Inherited Predisposition

Some of the most interesting developments in recent years are those which attempt to combine these two rather disparate approaches by demonstrating cellular defects in individuals with inherited predisposition to tumor formation. The assumption is made that several events are needed to convert a normal to a malignant cell and that at least one step is mutational. If such a mutation is inherited and thus fixed in all cells of the body, then cultured cells, like those of the individual

from whom they came, should either express an abnormality or be unusually susceptible to alteration by an exogenous agent. Studies of cultured cells from tumor-susceptible individuals have sought evidence for defects leading to sensitivity to cell-killing by mutagenic or carcinogenic compounds, for the presence or inducibility of chromosome damage, and for increased transformability to a malignant phenotype *in vitro* by oncogenic agents. Examples for each of these have been found within the hereditary tumor syndromes. Cultures derived from patients and family members with intestinal polyposis syndromes have shown increases in levels of polyploid cells at metaphase.[22] Alterations in control of DNA synthesis have also been described in association with these syndromes.[23] It is noteworthy that of the many attempts to induce malignant transformation of human cells *in vitro* by chemical carcinogens, one of the first reports of success resulted from exposure (to urethane) of cells from a tumor syndrome patient with Von Recklinghausen's neurofibromatosis.[24]

The largest number of experiments in this area have focused on a set of diseases which have in common autosomal recessive inheritance, apparent chromosome fragility, and extensive and early incidence of malignant tumors.[25]

Defective DNA synthesis or repair has long been suspected to be responsible for the complex of defects observed in these syndromes, which include Fanconi's anemia, ataxia telangiectasia, Bloom's syndrome, and xeroderma pigmentosum. Evidence for increased sensitivity to the cytotoxic effects of mutagens have been found: in Fanconi's anemia with mitomycin C,[26] in ataxia telangiectasia with several chemicals and radiation,[27] and in xeroderma pigmentosum with UV-irradiation.[28] The latter is relevant to tumor formation since xeroderma pigmentosum cells are deficient in their ability to repair UV damage to DNA and the patients show skin tumors. Cells from Bloom's syndrome patients appear to have slower rates of synthesis of DNA chains than is normal.[29] In our laboratory we have found that Fanconi's anemia and ataxia telangiectasia cells are susceptible to chromosome damage by exposure to chemical carcinogens at levels which are harmless to normal cells.[29] Increased susceptibility to transformation by the oncogenic virus SV40 has been reported for several of these syndromes.[30] Thus, cells from patients with some hereditary disorders which culminate in malignancy show genetically-determined abnormalities of response to cancer-causing agents.

The types of mutations to be expected in tumor-prone individuals are those relevant to the phenotypes of tumor cells. These are mutations affecting cell division, repair of DNA, and loss of metabolic regulators, which under certain circumstances could confer relative growth or survival advantage upon the cell. Specific loci might regulate expression of a tumor virus or be involved in enzymic activation of a carcinogen to its active form.

At this point it is not clear how many or what kinds of genes affect cancer susceptibilities or to what extent it is practical to limit environmental exposures. Some gene-determined cancer susceptibilities have been identified; many more are likely to exist. It may be appropriate to redirect our concern with environmental hazards to focus on differences in genetic susceptibility which limit or compound responses to exogenous agents and to concentrate our efforts on the identification and protection of high-risk individuals. ◀

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A complete set of references for "Environmental Factors, Genetics and Cancer," may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago IL 60603.



Case Reports

Vicarious Menstruation And Recurrent Catamenial Pneumothorax

BY RAYMOND A. DIETER, JR., M.D. AND GERALD LIESEN, M.D./GLEN ELLYN

Pneumothorax is frequently encountered in general thoracic and pulmonary medicine. Free air noted in the pleural space is seen in association with chest injuries, chronic lung disease (the chronic lunger), iatrogenic causes, and carcinoma. Idiopathic or spontaneous pneumothorax is a frequent cause of free pleural air. Most such problems develop in the young, slender, male patient. We are herein reporting of a patient who developed recurrent right pneumothorax and vicarious menstruation concurrent with her normal menstrual cycles.

Menstrual periods occur normally in the female aged from the early teens through the mid-forties. Vaginal bleeding occurs regularly in these individuals. Extra vaginal bleeding or menstruation is occasionally reported but certainly has a very low rate of occurrence. Physicians, especially obstetricians, are aware of the problem, but rarely see such a patient.

The patient was a 23-year-old caucasion female who was admitted with sudden right chest pain. Menarche had occurred at age 13. Upon entering college at age 17, she began to have intermittent hemoptysis—especially when lying in bed. Initially the relationship to her menstrual cycle was not recognized. The bloody sputum slowly and progressively became more noticeable and frightening. The hemoptysis developed at the onset of each period. She saw her family physician who counseled her on the etiology and advised no specific treatment. The hemoptysis continued until she became pregnant at age 20. No further bloody cough occurred until approximately five months after she delivered her child. Hemoptysis began to occur and slowly became more severe. She was taking Ovral® for control of her periods at this time. She developed pain in the right chest and mild hemoptysis eleven months later on the first day of her period. The pneumothorax (Figure 1) was treated with needle aspiration and rapidly cleared. Hemoptysis and chest pain recurred with each period until this admis-



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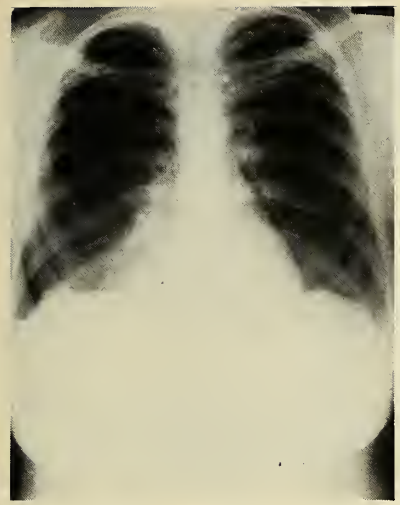


Figure 1

sion four months later. She was sitting in a chair at home when she developed the present right chest pain and hemoptysis. Chest X-ray demonstrated almost complete collapse of the right lung (Figure 2). Her past history revealed two ear operations and no bleeding abnormalities other than those mentioned above. On physical examination, diminished breath sounds on the right and increased resonance were noted.

At thoracotomy, a very pale, off-white atelectatic lung was seen containing multiple red, rather firm areas throughout all three lobes, suggesting small pulmonary infarcts. Several tiny intrapulmonary lymphoid aggregations were also present, but neither emphysematous blebs nor air leaks. Examination of the diaphragm failed to demonstrate any defects. Saline was instilled and positive pressure was applied to the lung with no leakage noted. Therefore, a right pleural abrasion and talc poudrage was performed after one of these reddened areas was wedge biopsied.

The pathologic specimen measured 1.5x1.3x0.4cm. and grossly contained blood. The alveoli were filled with red blood cells and many hemosiderin laden macrophages were found. The terminal bronchioles and pulmonary vessels were unremarkable. Adjacent to this area of fresh hemorrhage is an area of old reactive change with fibrosis and many hemosiderin laden macrophages with some alveolar thickening and atelectasis. The parietal pleura showed marked fibrous thickening with no inflammatory component. No endometriosis was noted.

Discussion

We have presented the case record of a 23-year-old caucasian female who had a history of hemoptysis in association with her menstrual periods for one year beginning at the age of eighteen. This vicarious menstruation then ceased when the patient became pregnant. No further hemoptysis occurred until she was nearly 22 years of age. She then had progressively more noticeable and distressing hemoptysis until the time of this admission. During this period of time, she was taking hormonal suppression with Ovral.® Eleven and fifteen months after this second onset of monthly vicarious menstruation, she developed right sided pneumothorax. The initial episode of catamenial pneumothorax (approximately 15-20%) was treated with repeated thoracentesis. The second episode of pneumothorax (near complete collapse) was treated with pleural abrasion and talc poudrage.

Most patients described with pneumothorax in association with their menstrual cycle are in the third decade of life or older.[1-4] The presently reported patient, is the youngest patient to be so described. The majority of catamenial pneumothoraces occur on the right side, as did the case presently reported. A great proportion of these patients have had exploratory thoracotomy with only approximately one-third of the individuals demonstrating endometrial tissue on the diaphragm or in the lung and only a few showing diaphragmatic perforations (three patients). Our patient did not demonstrate either diaphragmatic perforations or diaphragmatic or pulmonary endometriosis. Because patients have been reported to develop recurrent pneumothorax after thoracotomy without ablative surgery,[2] we elected to perform a procedure consisting of pleural abrasion combined with talc poudrage. She tolerated the procedure well and has had no further occurrence of the pneumothorax in the succeeding two years. The gross pathologic findings at surgery were unusual. The cause of the pale off-white color to the lungs is not apparent but this did not appear to be on a vascular occlusive basis. Major pulmonary vasculature appeared normal—as did the microscopic vasculature. The numerous elevated, firm and reddened lesions were dispersed throughout the three lobes of the right lung with no apparent organization. Microscopically, these lesions did not resemble endometriosis nor pulmonary emboli. They did show evidence of recent and old hemorrhage with the presence of erythrocytes and hemosiderin laden macrophages. Whether segmentectomy to include one or two of these lesions would have then demonstrated endometriosis proximal to

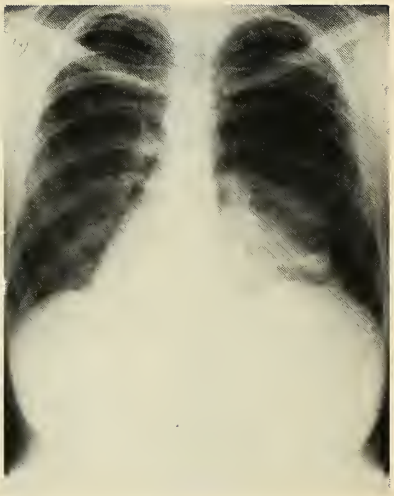


Figure 2

TABLE 1

Feature	All Patients	Our Patient	Feature	Some Patients	Our Patient
Rt. hemothorax	+	+	Evidence pelvic endometriosis	+	–
Related menses	+	+	Pleural endometriosis	+	–
Pneumothorax Other times	–	–	Perforations Diaphragm	+	–
Age onset	Late	Early	Failure to find pulmonary lead	+	+
Failure to occur if pregnant or on ovulation suppressing drugs.	+	+	Recurrent pneumothorax when no ablation	+	–

the hemorrhage is only speculative. This is at least a plausible consideration.

Lillington[2] did list features common to all patients with catamenial pneumothorax and those features found in some such patients. Table 1 lists those features and compares our patient with this group.

Some individuals with this syndrome have been subjected to laparoscopic diagnosis in the past to attempt to establish the existence of pelvic and/or abdominal endometriosis. At the same time, the insertion of intraperitoneal air may be used as a diagnostic procedure to ascertain if possible diaphragmatic perforations are present. In the future, diagnostic thoracoscopy should be given consideration for determining a possible etiology. At the same time, pleural ablation with talc or similar agents may be attempted. This could possibly save the patient the need for a thoracotomy.

Xray findings have demonstrated in all but three patients a pneumothorax on the right side on at least two occasions.[5,6] The present patient demonstrated similar findings. Only seven of the 19 patients described were found to have apical bleb formation. At least one patient was found to have bilateral pulmonary densities which disappeared after follow-up of ten days' time.[5] Recurrent right pleural effusion is also noted. Physicians, however, do not ordinarily record the presence of menstruation when patients are admitted with pneumothorax. Only one case of left catamenial pneumothorax was reported.[7]

Menstrual periods are not always associated with or accompanied by the vicarious menstruation or catamenial pneumothorax. However, the abnormal or vicarious menstruation is always associated with the menstrual period as are the catamenial pneumothorax. Our patient had a similar situation. She did not always have vicarious menstruation or catamenial pneumothorax, but when she did, it was associated with her normal menses. However ovulation suppression seems to prevent not only the pneumothorax, but the aberrant menstruation. Patient's symptoms ablated successfully with pregnancy and hormonal suppression in addition to the pleural ablation (both before and after pneumothorax). The presence of vicarious menstruation in this patient prior to her first pregnancy tends to disprove the theory of endometrial embolization due to pregnancy.[8]

Summary

A twenty-three year old white female developed vicarious pulmonary menstruation at the age of eighteen years. This was manifested by hemoptysis in association with the onset of her periods. Disappearance of symptoms occurred with pregnancy or hormonal (Ovral®) therapy. Upon cessation of the hormonal treatment she again developed hemoptysis and, in addition, catamenial pneumothorax on two occasions. Surgical pleural obliteration with talc poudrage and abrasion was then followed by oral hormonal therapy. No further symptoms have developed in the ensuing twenty-four months. ◀

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Case Reports

Total Removal

Arteriovenous Malformation Of the Cerebellar Vermis

By Nicholas J. Manno, M.D., And John H. Van Landingham, M.D./
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A case of a large arteriovenous malformation of the cerebellar vermis, fed by both superior cerebellar arteries, is presented. A three-stage surgical attack is described.

We have encountered and successfully treated a patient with a large arteriovenous malformation (AVM) involving the cerebellar vermis. This case is unusual not only because of the uncommon position of the lesion, but also because the nature of its major arterial blood supply (both superior cerebellar arteries) required careful consideration and planning prior to surgical attack, the outcome of which necessitated three intracranial procedures.

Infratentorial arteriovenous malformations are relatively uncommon compared with those of the cerebral hemispheres. In 1961, Verbiest[1] had found only 108 cases reported since 1914. Perret and Nishioka,[2] in the Cooperative Study (Section VI), found that among the 453 intracranial AVM collected, only 32 were infratentorial. Among these, 11 involved the brain stem, 16 involved a cerebellar hemisphere, and only 5 were in the midline of the cerebellum. Among the 21 lesions confined to the cerebellum, only three were resected, and these were hemispheric in location. Mount[3] reported the successful obliteration of a small AVM derived from the anterior inferior cerebellar artery. This lesion was attached to the pons and did not involve the cerebellum. An earlier report by Ciminello and Sachs[4] describes the treatment of a small AVM located over the vermis and right cerebellar hemisphere, fed by a single, enlarged intradural posterior meningeal artery. This vessel was clipped, and postoperative arteriography showed that it had been successfully occluded and that the AVM no longer filled. The radical excision of a large AVM replacing most of the right cerebellar hemisphere was described by Pool and Potts.[5] After first occluding the enlarged right superior cerebellar artery (the main feeding vessel) through a subtemporal approach, radical excision of the AVM was accomplished by removing the entire right cerebellar hemisphere, through a suboccipital approach.

More recently, Long, *et. al.*,[6] presented 12 cases of giant AVM in infancy and childhood. Among these lesions, one involved the posterior circulation, fed primarily from the superior cerebellar, anterior inferior cerebellar, and posterior inferior cerebellar arteries on the left side. The malformation was successfully entirely excised. The removal of a posterior fossa AVM supplied by the external carotid cir-

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Figure 1
Right brachial angiogram showing infratentorial midline arteriovenous malformation, supplied mainly by both superior cerebellar arteries. There is considerable siphoning from the right carotid circulation into the malformation.

culation was described by Graf and Menezes.[7] This lesion was situated in the region of the left cerebellar tonsil, inferior vermis and left cervicomedullary junction.

In the Japanese literature, Murakami, *et. al.*,[8] described the direct intracranial approach to an aneurysm accompanying an AVM, both arising from the peripheral portion of the right superior cerebellar artery. Total removal of a small AVM in the right cerebellar hemisphere was reported by Sato, *et. al.*,.[9] This lesion was fed by the right superior cerebellar artery. The case which most resembles ours is that reported by Nishikawa, *et. al.*[10] The major difference is that this lesion was fed by only one (the right) superior cerebellar artery. This difference is significant, however, since in our case the malformation was fed by both superior cerebellar arteries, a fact which compounded the operative approach.

Case Report

A 22-year-old right-handed male college student was admitted to Rockford Memorial Hospital 24 hours after severe, sudden, occipital headeache, vertigo and diaphoresis. Lumbar puncture by his local physician revealed bloody cerebrospinal fluid. On neurological exam, he was mildly obtunded, but arousable. Speech was normal. There were no cranial or cervical bruits. Ocular fundi were normal. Nuchal rigidity, paresis of conjugate vision to the right, and nystagmus when patient looked to the left were present. Bilateral limb ataxia of all four extremities, greater on the left, was evident. Hyperreflexia, greater on the right, was also present. The remainder of the neurological examination was normal. The gait and station were not tested. Bilateral brachial and left carotid angiography revealed a large midline infratentorial AVM fed primarily by both superior cerebellar arteries, both of which were enlarged and tortuous, especially the left (Figures 1 and 2). There was considerable siphoning from the right carotid circulation into the malformation.

Surgery

One week after admission the left superior cerebellar artery was occluded. This was accomplished through a left temporoparietal craniotomy approach. Following intravenous infusion of 500cc Mannitol (20%), the temporal lobe was retracted, exposing the tentorial notch. The medial edge of the tentorium was divided approximately 2cm to aid the exposure. The enlarged superior cerebellar artery was easily identified, both in its proximal and more distal course, encircling the cerebral peduncle. The distal segment was then elevated and occluded with a Heifetz clip.

Postoperatively, there was mild right hemiparesis and dysphasia, which cleared after one week. The patient also had one generalized convulsion 48 hours after this procedure. There were no subsequent seizures. A left carotid angiogram one week later was normal. Left brachial angiography demonstrated successful occlusion of the left superior cerebellar artery and continued opacification of the malformation. Three weeks after first surgery, a right temporoparietal craniotomy was performed, the right superior cerebellar artery was clipped, employing the same technique. There were no postoperative





Figure 2
Left brachial angiogram, subtraction technique demonstrating more clearly the size and extent of the malformation.



Figure 3
Right brachial angiogram, after both superior cerebellar arteries had been clipped. Later film in the series showing persistent filling of the malformation.

complications. One week following this procedure, right brachial angiography demonstrated occlusion of both superior cerebellar arteries and persistent filling of the AVM by branches of the vertebrobasilar circulation (Figure 3). Ten days after the second operation, suboccipital craniectomy and total excision of the malformation was accomplished. The lesion was situated within the posterior vermis and medial portions of both hemispheres. The larger dorsal feeding arteries were first clipped and divided. The malformation was then removed by coagulating, clipping and dividing those smaller arterial and venous channels immediately surrounding it. A firm hematoma within the medial hemispheres, remaining posterior vermis and fourth ventricle, was evacuated. Postoperatively, the patient exhibited moderate truncal ataxia, gait ataxia and dysmetria of the extremities, as well as a mild degree of apathy, all of which rapidly improved. Two weeks following the last operation, a left brachial angiogram showed no evidence of malformation (Figure 4.)

Follow-up exam one year later demonstrated only minimal tandem ataxia. The patient has corresponded yearly and was last heard from five years ago indicating that he had completed his studies and was employed as a high school English teacher.

Conclusion

Despite the size and position of this formidable lesion, careful planning prior to its total removal is paramount. We emphasize that occluding both superior cerebellar arteries in separate stages permitted the final total excision to be performed with relative ease.

It has been recognized that infarction of the pontine tegmentum results from occlusion of the superior cerebellar artery, producing ipsilateral Horner's syndrome and cerebellar dysfunction, and contralateral hemianalgesia. It is important to note that these deficits did not occur, despite the fact that both these vessels were purposely interrupted. ◀

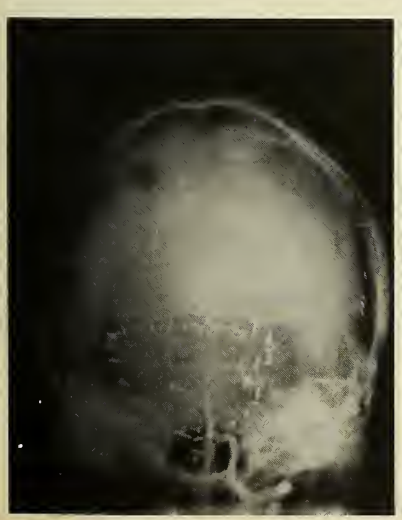




Figure 4
Left brachial angiogram showing no evidence of malformation.

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Surgical Grand Rounds

John M. Beal, M.D., Contributing Editor

Surgical Grand Rounds are held weekly on Tuesday, 5:00 pm in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 5, 1980.

Case Report

Reconstructive Microsurgery

Dr. Gerald Harris: Today I will discuss the present status of reconstructive microsurgery. The talk will be in two parts: first, I will consider replantation of amputated parts; and second, I will talk about elective reconstructive procedures which were virtually impossible just a few years ago. Cases which have been performed here since January, 1980, and a review of experience from elsewhere will be presented to demonstrate the scope of this technique.

For reconstructive surgeons, microsurgery is the restoration of function and contour by the replantation, transplantation, or reenervation of tissue by microvascular and microneural anastomosis. In general, the procedures can be divided into two categories: (1) those which involve immediate reconstruction and include replantation or revascularization of amputated parts in acute situations, as well as primary nerve repair; and (2) those procedures which are performed later when standard reconstructive procedures are inadequate.

The first illustrative case is that of a 30-year-old woman who was in an automobile accident. A metal guard rail went through her leg and fractured the fibula and tibia in multiple places. As a result of this injury, there was a 25cm x 8cm skin defect with exposed, fractured tibia. She was treated elsewhere with skin grafts in an attempt to close the skin defect. In addition, external fixation was used to immobilize the lower extremity. Although the grafts covered some of the soft tissue, the fractured tibia remained exposed. Five or six years ago, the leg of this 30-year-old woman almost certainly would have been amputated.

The patient was transferred to Northwestern Memorial Hospital three weeks after her initial injury. Her injuries at this time were limited to the left lower extremity where open tibia and fibula fractures were present (Figure 1). It was decided that an attempt would be made to salvage her leg using microvascular transplantation of a muscle flap. The purpose of the muscle flap was to provide a highly vascular coverage of the bone so that it could be reinforced with a bone graft at a later time. The muscle flap would also support skin grafts applied at the time of the initial surgery, thus allowing complete wound closure to be achieved in one operation. Skin coverage is essential to prevent the development of osteomyelitis.

Preoperative arteriography demonstrated that the anterior tibial artery was intact for a distance of approximately 6.0cm. (Figure 2). This artery was selected for end-to-end anastomosis to the



Figure 1.
Appearance of left lower extremity at time of admission. Exposed tibia is visible at base of wound.

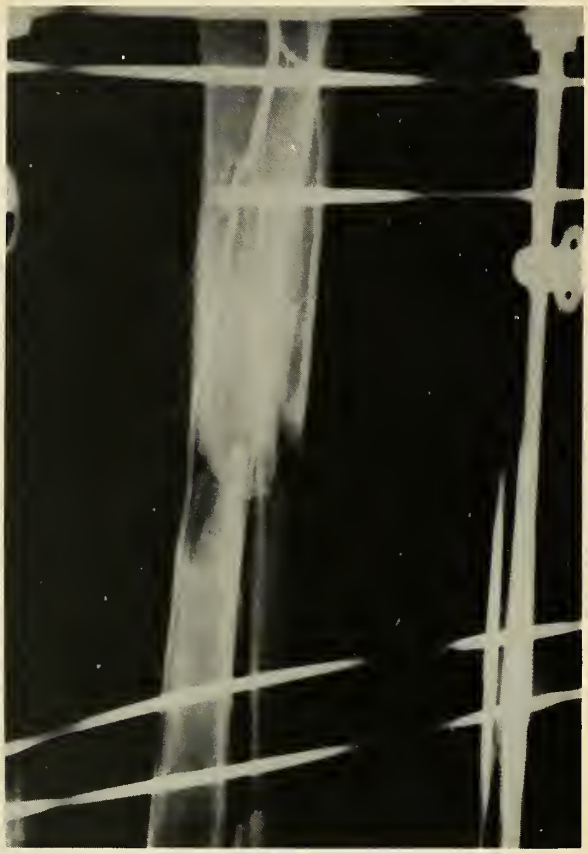


Figure 2.
Preoperative arteriography was performed so that an appropriate artery could be selcctcd for anastomosis.

thoracodorsal artery of the latissimus dorsi muscle. In the operating room, the recipient vessels were isolated in the wound. The anterior tibial artery and its accompanying vein were prepared for subsequent anastomosis. Having found the recipient vessels, we exposed the upper torso and isolated free the latissimus dorsi with its neurovascular pedicle containing the thoracodorsal artery, vein, and nerve (Figure 3). The muscle was transferred to the leg while a second team closed the donor site wound.

In general, the arterial anastomosis is completed first; however, in this particular case that was not possible. The patient had one uninjured vein associated with the anterior tibial artery and it was much deeper in the wound. For this reason, venous anastomosis was performed first.

There was some difficulty performing the venous anastomosis because it was found to lie beneath a Steinmann pin used for external fixation. The external fixation could not be taken down, however, because of the possibility of compromised vasculature of the leg if it were removed. Anastomosis of the thoracodorsal artery was carried out. The muscle flap with dimensions of 25cm x 12cm was well vacularized. Split thickness skin grafts were applied (Figure 4). Muscle and skin graft remained viable. The patient was discharged two weeks after her admission and was transferred back to Northern Michigan where a bone graft will be performed at a later date.

Second Case

A case was encountered at Children's Memorial Hospital recently. The child was seven years old. At the age of one year, he was burned in a severe house fire and lost all the skin of his entire scalp. The burn was so deep that in some areas there was loss of his skull. Multiple skin grafts were applied to the skull and dura mater. The child had never been free of scalp ulcerations and chronic infection. He had required the constant application of dressings. He was bald but he could never wear a wig because of the presence of chronic infection. In addition, one could actually observe the pulsations of the brain through the skin graft envelope. The skin graft did not pro-

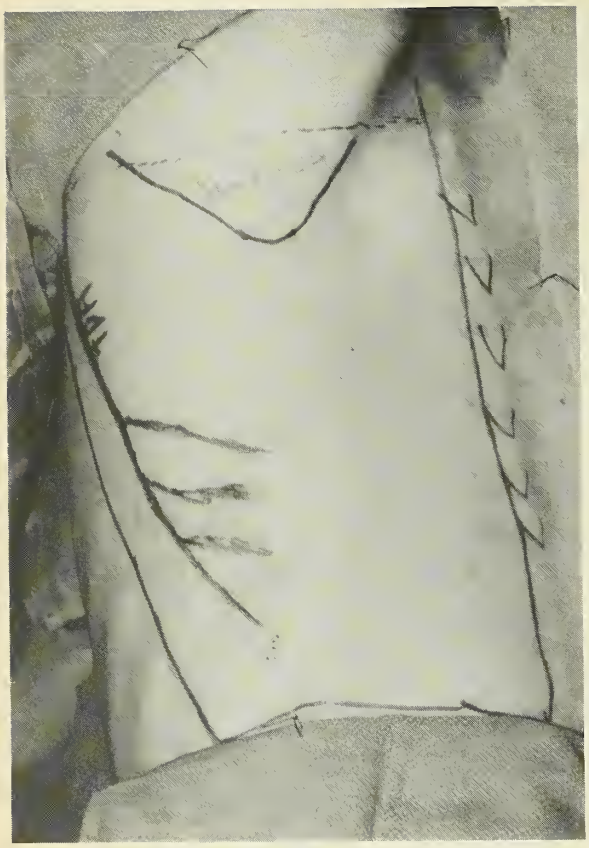


Figure 3.
The outline of the latissimus dorsi flap with neurovascular pedicle was drawn on the patient's chest wall.



Figure 4.
The appearance of the lower extremity after the placement of the muscle flap and coverage of skin grafts.

vide acceptable protection for the brain against even minor trauma. This lack of protection for the brain made it necessary for the child to wear a protective helmet.

Using the same muscle transplantation technique demonstrated in the previous case, it was possible to use the latissimus dorsi muscle and to anastomose it to the superficial temporal artery and vein. The latissimus dorsi muscle not only supported skin grafts applied to its outer surface, but it also made possible reconstruction of the skull by vascularizing split rib grafts which were applied at the same time as the muscle transplantation. This combined rib graft, muscle, and skin graft envelope provided solid protection against trauma to the brain, eliminated the chronic infection, and made it possible for the patient to wear a wig—an important consideration for a child in second grade. Denervation of the latissimus dorsi muscle results in its atrophy and this has given the reconstructed scalp an excellent contour. Both the patient and his family are delighted with the results.

In general, microvascular transplantation of composite tissues is most applicable in the upper extremity, lower extremity, and the head, where standard flaps are frequently unsatisfactory.

Hand Surgery

A 30-year-old farmer caught his hand in a grain auger and most of the vital structures in the palm of his hand were avulsed. The motor branch of the median nerve, the sensory branches of the median nerve, and all the flexor tendons were lost. In addition, multiple fractures of the metacarpals were sustained. Reconstruction of this hand would require bone grafting, the use of silastic rods, tendon grafts, and the use of nerve grafts.

All of these procedures require the presence of full thickness skin and subcutaneous tissue. Split thickness skin graft coverage is not sufficiently durable to support such operative procedures. For many years, when such injuries have occurred, it has been customary to resurface the hand by attaching it to the abdomen and then

dividing that attachment after approximately three weeks. Such flaps are parasitic. They derive their blood supply from the hand. These flaps are at risk whenever they are undermined in order to perform such procedures as bone grafts, insertion of silastic rods, insertion of tendon grafts, and insertion of digital nerve grafts.

For this reason, we elected to develop a groin flap to be transferred by microvascular transplantation. The blood supply of the groin flap was derived from the superficial circumflex iliac artery and vein which were anastomosed end-to-side to the radial artery and vein. The end-to-side anastomosis was necessary because the patient did not have an ulnar artery and an end-to-end anastomosis to the radial artery would have devascularized the hand. This anastomosis allowed the blood to continue to flow through the radial artery into the hand and, at the same time, to flow into the flap.

Such flaps sometimes require defatting because they are often too thick when applied. This is a simple procedure performed after all other reconstruction is complete. This particular patient has already undergone the insertion of silastic rods and tendon grafts. He will also undergo multiple nerve grafts in the near future. All of these procedures required undermining of the flap used to resurface the palm of the hand and there is little doubt that a parasitic flap deriving a blood supply from the underlying tissues would not have survived. Failure of the flap to survive would have resulted in failure of the tendon grafts, silastic rod insertions and digital nerve grafts.

General Considerations

I would like now to talk about general concepts relating to reconstructive microsurgery. Replantation of amputated parts has received the greatest publicity. Physicians, however, should be aware that there are absolute contraindications, relative contraindications and certain important exceptions to contraindications to replantation. Obviously, somebody who has a lacerated liver and spleen is not really a candidate for replantation of a finger or a hand. The most significant injuries must be treated first. An amputated part that is injured at more than one level is also considered unsuitable because there is really no great gratification in replacing a part that will not function. Therefore, if an arm was severed below the elbow and the nerves and tendons were also severed at the level of the wrist, you might be able to restore blood supply to the tissue without necessarily restoring function for the patient. Severe crush injuries are the most commonly abused contraindications. Crush injury eliminates runoff. A microvascular anastomosis requires adequate inflow and adequate runoff. In a crushing injury, this situation does not exist and the anastomosis is doomed to failure. Poor general health of the patient is an obvious contraindication. These operations may require from eight to twenty-four hours, depending on the type of injury and the number of parts to be replanted.

Relative contraindications include amputation of a single digit. More and more, replantation surgeons are recommending that a single digit amputation not be replanted. An index finger which has been amputated and replanted is often ignored by the patient because the finger seldom has sensation as good as that in the other fingers and the range of motion is also less than is present in the other fingers. For this reason, the patient tends to use his long finger as an index finger. The replanted index finger actually becomes an impediment and replanting the index finger may represent a disservice to the patient. In children, exceptions might be made simply because their vocation has not been established. Amputation of the small finger is also associated with a decreased range of motion and because the long, ring and small fingers have a common muscle origin for the flexor digitorum profundus tendons, a decreased range of motion of the small finger is also reflected in decreased motion of the ring and long fingers. Again, single digits, in most circumstances, should not be replanted. Avulsion injuries are notoriously complicated and they are in the same category as the crushing injury.

The period of warm ischemia time is also important. Because the finger contains no muscle, it can be ischemic for 24-36 hours if it is cooled immediately. If it is not cooled, the limit is in the range of 10-12 hours. However, an imputated part which contains muscle, such as a forearm or leg, is much more susceptible to the effects of warm ischemia. A muscle which has been subjected to warm ischemia for six hours is almost certain to undergo contracture and not be very functional. Therefore, there are limitations as to the amount of warm ischemia time which can be tolerated. It does, however, vary with the tissue which as been amputated.

To minimize warm ischemia an amputated part should be cooled as soon as possible. The proper way to cool an amputated part is to wrap it in a moist gauze sponge, place it in a plastic bag, and pack the bag in crushed ice. The finger should not be submerged in a solution of any kind and no preliminary debridement should be carried out at the referring center.

One final contraindication to replantation is extreme contamination. Loss of an arm in a manure spreader, for instance, would preclude replantation.

Exceptions to the previously mentioned contraindications to replantation should be considered very carefully. In children, an attempt is usually made to replace as much tissue as is possible. People who have lost multiple digits are candidates for replantation. A person who has had four fingers amputated is probably going to be better off with four stiff fingers than with no fingers at all. Finally, the thumb which is so extremely important to the hand, representing 40% of the function of the hand, should be replanted whenever a reasonable expectation of restoring sensation to the replanted tissue exists. The decreased range of motion associated with replanted parts is much less of a problem in the thumb, as it can be useful even if it serves as an immobile post against which the other fingers can pinch.

Postoperative Considerations

Preoperative considerations are important. Principles of care are the same as for trauma in general. Control of hemorrhage is usually easily achieved by means of a properly applied compression dressing. Resuscitation of the patient is of primary importance. Replantation of an arm often is associated with transfusion of 20-30 units of blood, much of which had been lost in the preoperative period. It is important to emphasize again the care of the amputated part. The part should be wrapped in moist gauze, properly placed in a silastic bag, and *not* submerged in liquid. The plastic bag should be packed in ice and the part sent with the patient to the replantation center. In certain situations, where the patient requires initial resuscitation at the referring center, the part can be sent ahead to the replantation center for debridement, labeling of structures etc., in an attempt to save time.

When we accept a replantation in transfer, we request that antibiotics be administered. At the replantation center the amputated part is debrided, the neurovascular structures are labeled, the tendons are labeled, and the bone is prepared for fixation. The actual replantation follows a general scheme. First, the bone is repaired. This is as important as the vascular anastomosis because if good bone healing does not occur, or if there is non-union or malunion, the replanted digit will be of little value.

Next to be repaired are the tendons. First, the flexor tendons are repaired and then the arterial anastomosis is carried out. In general, the delicate procedures are performed last. It is extremely easy to disrupt an arterial or nerve anastomosis during the process of placing interosseous wires or K-wires, as well as during the process of tendon repair. In finger replantation, therefore, after the bone and flexor tendon have been repaired, the artery is repaired. The volar digital nerve is sutured. The hand is turned over and the dorsal veins are anastomosed. Finally, the skin is closed. Skin grafts are used liberally to avoid compression of the vascular structures by the swollen skin and subcutaneous tissues. Arterial anastomosis is performed first to avoid wasting time doing venous anastomosis for a part which cannot be revascularized. In addition, by doing the arterial anastomosis first, it is easier to determine which veins are functional. There is a certain amount of vascular injury associated with the trauma of amputation.

Successful microvascular anastomoses require that any injured vessel be resected. It becomes necessary to shorten the amputated part by shortening the bone or using innerposition vein grafts to bridge the gaps created by debridement of the injured vessels. The introduction of vein grafts has been a highly significant addition to microvascular surgery. Until vein grafts were used on a routine basis, success rates in replantation seldom exceeded 50%. Now, with the use of vein grafts, and when dealing with favorable amputations such as those which are guillotine amputation or injuries with a fine type of saw, replantation success rates may approach 80%-90%.

The level of amputation is also very important. Any amputation beyond, or distal to, the distal interphalangeal joint probably does not merit the operative risk and expense associated with its being replanted.

Post-operative care is very important. Frequent post-operative observation is essential. These patients have been subjected to long operative procedures; therefore, pulmonary toilet, proper fluid and electrolyte balance are essential. In addition, the function of the arterial and venous anastomoses must be assessed on an hourly basis for the first twenty-four hours. By carefully monitoring the vascularity of the replanted part, thrombosis can be discovered early, reexploration can be carried out, and up to 50% of these replanted parts can be salvaged by a single exploration and reconstruction of the anastomosis.

Currently, we use low molecular dextran and aspirin in the immediate post-operative period. Heparin is used only in serious situations where the tissue has been badly injured and there is doubt as to the quality of the arterial reconstruction. In our first ten cases involving microvascular procedures here at Northwestern, Me-

morial, we have used Heparin only once. Any discussion of replantation requires consideration of the late complications. If bone has been improperly immobilized or aligned, or it does not have an adequate blood supply, malunion or nonunion may occur. This can have a devastating effect on the quality of the replanted part. We have already mentioned that muscle contracture will result from prolonged warm ischemia. Inadequate sensation has been mentioned and serves to limit function of the replanted part. Joint stiffness is a common problem with replanted parts. In general, all the problems associated with hand surgery in relation to scarring and poor range of motion are present in replantation surgery. Everyone has seen a patient whose injured flexor tendon, although repaired by a competent surgeon, still lacked full range of motion because of a scar. It is not surprising, then, that range of motion is often less than ideal when the scar is related not only to the division of the flexor tendon, but also to division of the bone, division of the extensor tendon, and a circumferential skin laceration.

Replantation represents the best method yet for reconstructing the severely injured hand when a significant portion of the hand has been lost through amputation. The replanted part will be of maximum value to the patient, however, only if careful attention is paid to the proper indications for, and contraindications to, replantation. Finally, exacting microsurgical technique is essential during the operative procedure.

Amputations of the hand are not the only amputated parts which have been replanted. Dramatic results have been achieved by the replantation of totally avulsed scalps. Amputated parts of the face resulting from dog bites or other trauma and amputations of the lower extremities, especially in children, have also been replanted.

One final and very common application of microsurgical technique should be included in this discussion. Use of the operating microscope to repair lacerated nerves allows the best possible alignment of the nerve tissue. Groups of funiculi or individual funiculus can be aligned according to size, shape and location. By so doing, the best possible restoration of function will be achieved. In addition, the use of microsurgical instruments allows delicate handling of the nerve so that partially transected nerves can be explored soon after the injury. This will allow these partially divided nerves to be repaired without loss of the function of the intact portion of the nerve. These advantages have also been demonstrated many times in the performance of nerve grafts to overcome gaps resulting from old nerve injuries. ◀

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

April 26	Victory Memorial Hosp. & A.C.S.	Waukegan
April 28	St. Francis Hosp. & A.C.S.	Blue Island
May 4	Sherman Hosp. & A.C.S.	Elgin
May 4	Rock Valley College	Rockford
June 16	Decatur Memorial Hosp. & A.C.S.	Decatur
June 22	Blessing Hosp., A.C.S., 7th Day Adventist Church	Quincy
June 22	Copley Memorial Hosp. & A.C.S.	Aurora
August 24	YWCA	Rockford
Sept. 8	St. Francis Hosp. & A.C.S.	Blue Island
Oct. 19	Sherman Hosp. & A.C.S.	Elgin
Oct. 20	Lutheran General Hosp. & A.C.S.	Park Ridge
Oct. 20	Decatur Memorial Hosp. & A.C.S.	Decatur
Oct. 22	St. Mary Hosp., A.C.S., 7th Day Adventist Church	Quincy
Bi-Monthly	Skokie Valley Hosp.	Skokie

Quarterly Report: April 1-June 30, 1980

Formal Decision Regarding Discipline Of Medical Professionals Ordered by the State of Illinois Department of Registration and Education

This report includes formal decisions regarding issuance, refusal to issue, restoration, renewal or refusal to renew, revocation and suspension of licenses and probationary or other disciplinary action taken by the Department. It does not include formal decisions involved in the Director's approval of board or committee recommendations to issue licenses to persons passing licensure examinations.

MEDICAL PROFESSION

FORMAL DECISIONS REGARDING DISCIPLINE
ORDERED BY THE DEPARTMENT OF REGISTRATION AND EDUCATION

Name & Address Profession	Act (Ill. Rev. Stat.) & Section And/Or Rule Violated	Discipline Ordered Case Number	Date Ordered
Julius Mussil 4948 Dempster Skokie, Illinois 60067 MEDICAL DOCTOR 003-36-16437	Chpt. 111, Sec. 4433 Respondent had previously surrendered his Controlled Substances license. No admissions of guilt were made.	Termination of Controlled Substances License to prescribe Schedules II, IIN, III, IIIN & IV. Consent Order 80-9	4-1-80
Andres S. Sendin 516 Sutter Street #405 San Francisco, Ca. MEDICAL DOCTOR 36-38430	Chpt. 111, Sec. 4433 (4) (11) Respondent's license to practice medicine in another state was revoked.	Indefinite Suspension 79-152	4-14-80
Victor Wojnar 301 East University Ave. Champaign, Illinois MEDICAL DOCTOR 36-39385	Chpt. 111, Sec. 4433 (4) (12) (19) & (22) Respondent failed to provide adequate control for potential diversion of dangerous and controlled drugs.	2 Months Suspension, One year Probation of Medical License 79-4	5-5-80
William Yacullo 1930 North Harlem Elmwood Park, IL 61259 MEDICAL DOCTOR CONTROLLED SUBSTANCES 36-23227 003-036-023227-1	Chpt. 111, Sec. 4433 (19) Wrote prescriptions for non-therapeutic purposes.	3 year Probation of Medical License; Surrender of Controlled Substances License Consent Order 80-7	5-5-80
Lawrence Lerner 6218 S. Central Chicago, IL 60638 MEDICAL DOCTOR 36-48969	Chpt. 111, Sec. 4433 Respondent admitted that he was convicted of a drug-related misdemeanor and that his California license was revoked; said revocation was stayed for ten years.	2 year Probation Consent Order 77-81	5-5-80

Name & Address Profession	Act (Ill. Rev. Stat.) & Section And/Or Rule Violated	Discipline Ordered Case Number	Date Ordered
Charles Sasson 2635 Walnut Street Huntington Park, CA MEDICAL DOCTOR 36-37708	Chpt. 91, Sec. 4433 (3) (27) Respondent evidenced gross malpractice and professional incompetence.	One Year Suspension 79-29	5-12-80
Vernon Paul Banning 410 North Second St. Marshall, IL 62441 MEDICAL DOCTOR 36-42536	Chpt. 111, Sec. 4433 (4) Respondent was convicted of income tax evasion in U. S. District Court	Reprimand 79-169	5-12-80
Abraham I. Jackman 861 North LaSalle Chicago, Illinois 60610 MEDICAL DOCTOR 36-22863	Chpt. 111, Sec. 4433 (19) Respondent failed to exercise good faith in issuing prescriptions for Preludin.	Revocation of Controlled Substances Certificate; Indefinite Suspension of Medical License Consent Order 79-121 & 79-129	5-16-80
Sinisa Princevac 5011 North Lincoln Chicago, Illinois 60625 MEDICAL DOCTOR 36-49181	Respondent demonstrated professional incompetence as manifested by poor standards of care.	60 Day Suspension 2 Year Probation 79-13	5-30-80
Carter Weinke 2800 Milwaukee Avenue Chicago, Illinois 60619 MEDICAL DOCTOR 36-25521	Chpt. 111, Sec. 4433 (19) Wrote improper prescriptions for Controlled Substances.	15 Day Suspension, 6 Month Probation of Controlled Substances License Consent Order 79-179	6-26-80
Regaldo S. Florendo 12800 S. 86th Street Palos Park, IL 60464 MEDICAL DOCTOR 36-44757	Chpt. 111, Sec. 4433 Failed to maintain patient records	Censure Consent Order 78-129	6-26-80

Editor's Note: This is the most recent quarterly report available at the time of publication.

EKG

(Continued from page 216)

Answers: 1. E 2. A. B.

The carotid sinus massage (R-CSM) in the top panel caused some sinus slowing but it had a greater effect on AV conduction. The pacemaker (P) escapes and functions well. The pacemaker is set at a rate of 52 beats per minute to give the sinus mechanism every chance to conduct. In the last panel, there is an episode of spontaneous second degree AV block. The sinus rate is stable at 75 beats per minute. There is a slight lengthening of the PR interval of the last conducted beat (the sixth beat from the left in the last strip). The bars mark the P waves and the diagrams show the slight lengthening of the PR interval. In the top panel, carotid sinus massage caused a greater slowing in AV conduction than in sinus slowing. This is not unusual. However, the spontaneous development of second degree AV block is another consideration. This pattern was a clue that myocardial damage had occurred. The patient had no pain complaints with his tachycardia and the ECG of complete left bundle branch block prevented further ECG diagnosis. Subsequent serum enzymes confirmed the suspicion of an acute myocardial infarction. The ECG after cardioversion initially only showed ST-T waves compatible with ischemia. Two days later the ECG developed Q waves of inferior wall myocardial infarction. There was no recurrence of atrial flutter and the patient made an uneventful recovery. ◀

Pulse of the ISMS Auxiliary

REFLECTIONS: 1980-81

By Mrs. Harlan J. Failor, Immediate Past Pres., ISMSA



One year ago, in my President's Acceptance Message, I proposed to my fellow Auxilians that to look at the Auxiliary was to look at ourselves, for the Auxiliary is simply a reflection of its members. With this in mind, the mirror became symbolic of our 1980-81 objectives. It stood for the honest perception of *what we were* and for the exciting visualization of *what we could be.*

Dedicated to helping County Auxiliaries realize this potential, the ISMS Auxiliary sponsored for the first time two Leadership Seminars subtitled "Enhancing Our Image." The ISMSA Fall Conference provided a different perspective with the theme "Through the Looking Glass," and Auxilians from every District took a *Look at . . . Something New in Membership, AMA-ERF Fund Raising, Projects That Work,* and the *Power in Politics.* The Auxiliary's 1981 Convention afforded us one final opportunity to observe ourselves as we reported on the year's accomplishments in "Reflections: 1980-81."

I liked what I saw when I looked at the Illinois State Medical Society Auxiliary twelve months ago, but I find even more to admire today:

While our spouses have been in their offices healing illness, we have been in our communities teaching wellness. Something has been offered to every age group: *Vial of Life,* an emergency program for senior citizens; *Health Careers,* educational opportunities for teenagers; *Nutrition Puppet Shows,* wholesome diets for youngsters; *Immunization,* required protection for infants and children; and *Shape Up For Life,* a nation-wide campaign to convince everyone that eating right and exercising regularly are the way to establish and maintain optimum health.

Recognizing that the future of our organization is in the hands of resident physicians' and medical students' spouses, the Auxiliary this year instituted a new membership program called SASII—Sponsor a Spouse in Illinois. The ISMSA sponsor pays the five dollar state and national dues of a student spouse providing her with the many benefits of Auxiliary membership and the incentive to actively participate in the future.

This spring a new legislative program was introduced. Auxiliary members are being asked to monitor Health System Agency Board and Committee meetings and report HSA actions to the medical community. If there was ever a call to partnership, it is the challenge of these new regulations by government.

A new media project has been undertaken which will bring our "Is He Sick? Should I Send Him To School" brochure to the attention of radio and television audiences throughout Illinois. All of these activities mirror the Auxiliary at its best, and the image is a gratifying one.

If we see ourselves when we look at the Auxiliary, then we must see our spouses when we look at the Society. Through our organizations we have become partners in medicine, as well as partners in marriage. At no time in history have our members worked so closely as they do today, with more Auxilians serving on Society councils and committees than ever before. We have come that proverbial "long way" from May 1922 when the Auxiliary was organized "to assist in entertainment at all medical conventions."

It has been a great privilege to serve as ISMSA President. From both the Auxiliary and the Society I have received unfailing support and friendship and an opportunity for personal growth without equal. For all of this the phrase seems inadequate, but *thank you.* ◀

Student Business Section in Action

Medicine vs. The Media

This is the fifth of a five-part series on cigarette advertising

Previous columns in this series have discussed how unregulated cigarette advertising has succeeded in increasing cigarette consumption and virtually silencing the media on the dangers of cigarette smoking. Recognizing the tremendous toll on human life for which tobacco is responsible, how is the medical profession to respond to this scandal?

Organized medicine has at least spoken out on this issue. ISMS has urged the *Chicago Tribune* and *Chicago Sun-Times* to refuse to accept cigarette ads, and has even gone on record in favor of banning all cigarette advertising (ISMS resolutions 79N-43, 80I-28). The AMA recently agreed to urge the 100 most widely circulating newspapers and magazines in the country to refuse to accept cigarette ads (AMA resolution 76, I-80). Not surprisingly, though, this "war with words" has failed to convince the media to put principle before profit.

A group of health professionals, however, called Doctors Ought to Care (DOC), has come up with several innovative approaches to fight the tobacco industry's propaganda. DOC, as part of its many health promotion efforts, has embarked on a counteradvertising campaign to discourage the lethal habits that are so prevalent in our society. Many of its counterads, such as the one that accompanies this column, use the same Madison Avenue techniques that are so successfully employed by the cigarette companies.

Alan Blum, M.D., founder of DOC, also suggests that physicians replace waiting-room magazines that accept cigarette ads with ones that do not. If enough physicians took this advice, *and let publishers know about it,* some magazines might be compelled to seriously reconsider their advertising policies. The financial incentive seems to be the only one to which they would respond. A list of magazines that do not accept cigarette ads appeared in the Nov. 7, 1980 issue of *American Medical News.*



For more information on DOC, write: DOC; 924 W. Webster St.; Chicago, Illinois 60614.

Ronald M. Davis
Delegate, ISMS-SBS

This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Student Business Section.

Viewbox

(Continued from page 222)

Diagnosis: Acute Cholecystitis—^{99m}Tc-IDA Study

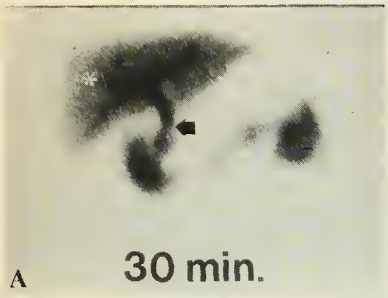


Figure 2A

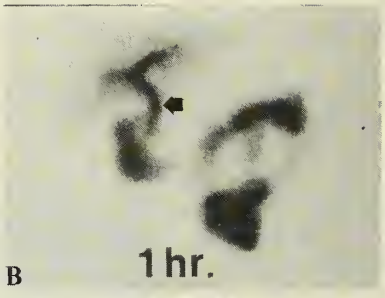


Figure 2B

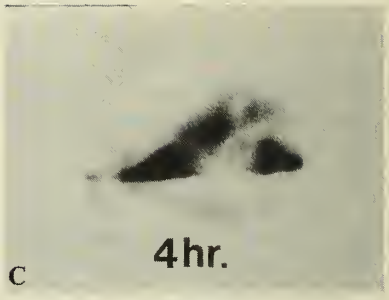


Figure 2C

Fig. 2—Abnormal cholescintigram
Serial scans demonstrate normal hepatic uptake (asterisk) with visualization of the common bile duct (arrow) and small bowel. No gallbladder is identified up to 4 hours indicating acute cholecystitis.



Figure 3A

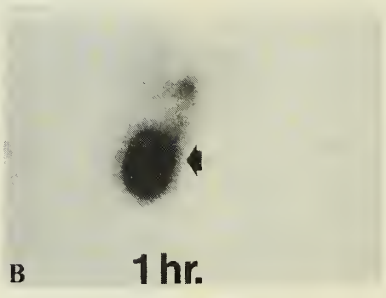


Figure 3B

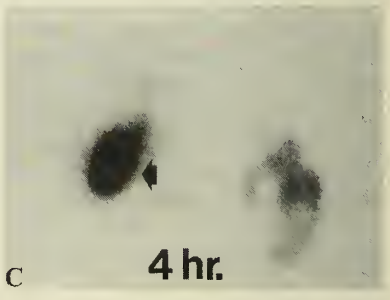


Figure 3C

Figure 3—Normal cholescintigram
Serial scans up to four hours demonstrate normal hepatic uptake and excretion, with an easily identified gallbladder (arrow).

The findings on the supine film of the abdomen are nonspecific. While all possible diagnoses given should be considered, the next logical step in the workup of this patient would be a ^{99m}Tc-IDA study in light of the high clinical suspicion of acute cholecystitis. The ^{99m}Tc-IDA study reveals non-visualization of the gallbladder (Figure 2) thus making the diagnosis of acute cholecystitis which was confirmed by surgery.

Cholescintigraphy is a rapid and accurate means of diagnosing acute cholecystitis. Nuclear medicine imaging of the hepatobiliary is not only more accurate and faster than previously available imaging procedures, but also has no reported associated morbidity.

A number of ^{99m}Tc-IDA derivatives have been developed. These agents differ predominantly in their hepatocyte extraction rate and their rate of transfer from the hepatocyte to the bile, so that they differ in their ability to image at elevated bilirubin levels.

Oral cholecystography has limited utility in the

rapid diagnosis of acute cholecystitis. There is a minimum delay of 12 hours between administration of oral contrast material and radiographic examination of the gallbladder. This is necessitated by the time needed for the intestinal absorption and hepatic conjugation of the contrast. In addition, there are other causes of non-visualization of the gallbladder other than acute cholecystitis.[1] Delayed gastric emptying, impaired hepatic function, vomiting, pancreatitis and most commonly, chronic cholecystitis, will all result in non-visualization of the gallbladder which does not give the clinician a definitive diagnosis.

Intravenous cholecystography fails to opacify the biliary tree in 30% to 50% of the patients with either acute cholecystitis or upper abdominal pain from other causes.[2] Anaphylactic reactions to the contrast occur in one out of 400 cases with a reported mortality of 1 in 5,000 patients.[3]

A significant limitation of intravenous cholangiography is the inverse relationship of the visualization of the biliary system and the bilirubin level. Visualization is significantly decreased when the patient's bilirubin is in the range of 2-4mg/100ml. Above 4mg/100ml the chances of visualization are less than 10%.[1] Depending on the ^{99m}Tc-IDA derivative used, the biliary system may be visualized up to 30mg/100ml of bilirubin.[1]

Ultrasonography accurately diagnoses the presence of gallstones. However, the presence of gallstones in a patient with right upper quadrant pain is not automatically equated with acute cholecystitis. Ultrasonography may diagnose cystic duct obstruction if a gallstone is found in the region of the cystic duct or in the neck of the gallbladder. In addition, Handler[4] and Marchal, *et al.*,[5] have attempted to correlate thickening of the gallbladder wall as measured by ultrasonography with the presence of acute cholecystitis. However, a thin gallbladder wall on ultrasonography does not exclude acute cholecystitis.

Computed tomography offers superior anatomic detail of the liver, pancreas and spleen. However, as of this date, it is not a procedure of choice in diagnosing acute cholecystitis.

Following the injection of the ^{99m}Tc-IDA biliary agents, the normal liver achieves maximal uptake at 10 to 15 minutes. The biliary tract normally is visualized at 15 to 30 minutes post-injection with 97% of normal gallbladders visualized by four hours.[6, 7] Liver washout is nearly complete by four hours (Fig. 3). A delay in washout may be seen in hepatic parenchymal disease as well as mechanical biliary tract obstructions.[8]

Acute cholecystitis is usually accompanied by obstruction of the cystic duct. In the proper clinical setting, failure to visualize the gallbladder is indicative of acute cholecystitis (Fig. 2). Visualization of the gallbladder by the ^{99m}Tc-IDA agents indicates a patent cystic duct and excludes acute cholecystitis with an accuracy of approximately 95%.[6] The 5% false negatives (gallbladder visualized) are felt to be due to chronic and acalculus cholecystitis.[6, 9]

Due to the spatial resolution in Nuclear Medicine, the role of cholescintigraphy in the diagnosis of chronic cholecystitis is limited. The presence of gallstones or thickening of the gallbladder wall cannot be evaluated with this imaging procedure. However, the diagnosis of chronic cholecystitis is suggested, but not certain, if there is faint visualization or delayed visualization of the gallbladder.[1] Oral cholecystography and/or ultrasonography remain the imaging procedures of choice of chronic cholecystitis.

The ^{99m}Tc-IDA agents may also be used in clinical situations other than acute cholecystitis. The agents are indicated in cases of traumatic bile leakage,[10] and in the evaluation of biliary-enteric bypass patency[1] where computed tomography and ultrasonography may leave the diagnosis in doubt. ◀

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Psychiatry

Working with Suicidal Patients
For: MD's. Lecture, May 20, 1:00 p.m., Forest Perk. **Speaker:** Robert Drye, MD. **Sponsor:** Riveredge Foundation, 8311 West Roosevelt Rd., Forest Park 60130. **Fee:** $15. **Reg. limit:** 200. **Credit:** Category 1, 3 hours. **Contact:** Susan Cosgrove. **Phone:** 312/771-7000.

Substance Abuse

Multiple Substance Abuse Workshop for Health Care Workers (Physicians)
For: MD's. Workshop, May 5, Park Ridge. **Sponsors:** Illinois Dangerous Drugs Commission; Lutheran General Hospital, 1775 Dempster St., Park Ridge. **Reg. fee:** $15. **Credit:** Category 1, 5 hours. **Contact:** Joseph DiFiore. **Phone:** 312/822-9860.

Surgery

Update on Surgical Infections
For: MD's. Symposium, May 13-15, Chicago. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood, Chicago 60612. **Reg. deadline:** 5/13. **Fee:** $225; $100. **Reg. limit:** 350. **Credit:** Category 1, 19 hours. **Contact:** Toni Hau, MD. **Phone:** 312/996-6771

Surgery

Surgery for the Complications of Myocardial Infarction
For: MD's. Lecture, May 13, 11:00 a.m., Chicago. **Sponsor:** Martha Washington Hospital, 4055 N. Western Ave., Chicago 60618. **Speaker:** John Moran, MD. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour; AAFP Elective, 1 hour. **Contact:** R. Bradkowski. **Phone:** 312/583-9000 x 332.

Surgery

The Covert Culprit: The Nasopharynx
For: MD's. Lecture, May 1, Chicago. **Speaker:** David Austin, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Robert Mutterperl, DO. **Phone:** 312/883-2112.

Surgery

Hyperalimentation—1981 Update.
For: FP's. Internists, Surgeons. Seminar, May 9, Chicago. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Reg. deadline:** 5/2. **Fee:** $100. **Reg. limit:** 120. **Credit:** Category 1, 6 hours; AAFP Prescribed, applied for. **Contact:** Robert Mutterperl, DO. **Phone:** 312/883-2112.

Surgery

Advances in Surgery
For: General and Specializing Surgeons. Lecture, May 4-8, Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $325. **Reg. limit:** 100. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker. **Phone:** 312/733-2800.

Trauma

25th Annual Postgraduate Course on Fractures and Other Trauma
For: Surgeons, Emergency Room Physicians, GP's. Course, May 20-23, Chicago Marriott Hotel. **Speaker:** Robert Salter, MD. **Sponsor:** Chicago Committee on Trauma of the American College of Surgeons, 55 E. Erie, Chicago 60611. **Fee:** $275; $100, allied health professions and residents/interns. **Reg. limit:** none. **Credit:** AMA Category 1, 28 hours; AAFP Elective, 28 hours; ACEP Category 1, 28 hours. **Contact:** Jack Robbins, MD. **Phone:** 312/475-4040.

JUNE

Cardiac Rehabilitation

Comprehensive Cardiac Rehabilitation Workshops
For: MD's, RN's. Workshops, June 8-12 or June 15-19, La Crosse, WI. **Sponsor:** La Crosse Exercise Program, Workshop Unit, Mitchell Hall, University of WI—La Crosse, La Crosse, WI 54601. **Fee:** $450. **Reg. limit:** 50. **Credit:** Category 1, 38 hours; AAFP Prescribed, 43 hours. **Contact:** Philip Wilson. **Phone:** 608/785-8686.

Cardio Pulmonary Resuscitation

Symposium on Cardio Pulmonary Resuscitation
For: MD's. Symposium, June 26, 11:15 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

Cardiology

Electrophysiologic Basis for Diagnosis and Management of Cardiac Arrhythmias
For: Cardiologists, Cardiovascular Surgeons, FP's, GP's, Internists. Conference, June 4-6, Milwaukee, WI. **Sponsor:** U of W—Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** 5/20. **Fee:** yes **Credit:** Category 1, 18 hours; AAFP Elective, 18 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Chest Medicine

Flexible Fiberoptic Bronchoscopy
For: Chest Physicians, Surgeons. Course, June 4-6, Continental Plaza Hotel, Chicago. **Speaker:** L. Penfield Faber, MD, FCCP. **Sponsor:** American College of Chest Physicians, 911 Busse Highway, Park Ridge 60068. **Credit:** Category 1, 15 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

Emergency Medicine

Topics in Emergency Medicine
For: Emergency Room Physicians. Seminar/workshop, June 1-5, Detroit, MI. **Sponsor:** Wayne State University School of Medicine, CME, 98-32 University Clinics Bldg., 4201 St. Antoine, Detroit, MI 48201. **Reg. deadline:** 5/22. **Fee:** $500. **Reg. limit:** 20. **Credit:** Category 1, 35 hours; ACEP, Category 1, 35 hours. **Contact:** Gerald Prieur, Jr. **Phone:** 313/577-1180.

Gynecology

Adolescent Gynecology
For: MD's. Lecture, June 23, 7:00 p.m., Kankakee. **Speaker:** George Maroulis, MD. **Sponsor:** Riverside Medical Center, 350 N. Wall St., Kankakee 60901. **Reg. limit:** none. **Fee:** $3. **Credit:** Category 1, 2 hours. **Contact:** Lisa Mitchell. **Phone:** 815/933-1671.

Gynecology/Surgery

Open Laparoscopy Workshop
For: MD's. Workshop, June 6, Chicago. **Speaker:** Harrith Hasson, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** $150, MD; $75, residents. **Reg. deadline:** none. **Contact:** Robert Mutterperl, DO. **Phone:** 312/883-2112.

Medicine

Approach to the Patient
For: MD's. Lecture, June 11, 1:00 p.m., North Chicago. **Speaker:** Bruce Rothschild, MD. **Sponsor:** North Chicago VA Hospital, UHS/CMS, North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss. **Phone:** 312/689-8010 x 375.

Medicine

Rheumatology & Surgery
For: MD's. Lecture, June 17, 11:00 a.m., North Chicago. **Speaker:** Bruce Rothschild, MD. **Sponsor:** North Chicago VA Hospital, UHS/CMS, North Chicago 60064. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss. **Phone:** 312/689-8010 x 375.

Medicine

Uses & Abuses of Estrogen Therapy
For: MD's. Lecture, June 5, Chicago. **Speaker:** Arthur Herbst, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Robert Mutterperl, DO. **Phone:** 312/883-2112.

RECENT CME ACCREDITATIONS

The ISMS Committee on CME Accreditation has approved the CME programs of the following institutions:

- **Augustana Hospital, Chicago**
- **Holy Cross Hospital, Chicago**
- **Martha Washington Hospital, Chicago**
- **St. Anthony Hospital Medical Center, Rockford**
- **St. Francis Hospital, Blue Island**
- **St. Francis Hospital-Medical Center, Peoria**

Medicine

Osteoporosis Disease
For: MD's. Lecture, June 19, Chicago. **Speaker:** Robert Recker, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 1 hour. **Contact:** Robert Mutterperl, DO. **Phone:** 312/883-2112.

Neurosurgery

Neurosurgical Intensive Care Symposium
For: MD's, RN's. Lecture, June 11-12, Madison, WI. **Sponsor:** U of W—Extension, CME, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. limit:** none. **Credit:** Category 1, 17 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Shock

Symposium on Shock
For: MD's. Symposium, June 5, 12 & 19, 11:15 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park 60304. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

Sports Medicine

82nd Annual Convention and CME Seminar
For: MD's. Lecture/panel, June 21-24, Lake Geneva, WI. **Sponsor:** Illinois Assn. of Osteopathic Physicians and Surgeons, 470 State St., Marseilles 61341. **Reg. deadline:** none. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1 26 hours; AOA, 26 hours. **Phone:** 815/795-6116.

JULY

Cardiac Rehabilitation

Comprehensive Cardiac Rehabilitation Workshops
For: Primary Care Physicians, allied health workers. Workshop, July 13-17 or July 20-24, La Crosse, WI. **Reg. deadline:** none. **Fee:** $450. **Reg. limit:** 50. **Credit:** Category 1, 38 hours; AAFP Prescribed, 43 hours. **Sponsor:** La Crosse Exercise Program, Workshop Unit, Mitchell Hall, U. of WI-La Crosse 54601. **Contact:** Dr. Philip Wilson. **Phone:** 608/785-8686.

ADVANCE NOTICE

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Doctor's News

PHYSICIANS IN THE NEWS—Lawrence L. Hirsch, M.D., recently received an AMA National Bronze Award through their medical speakers program for his speech entitled "Doctors Do Care." Dr. Hirsch, immediate past president of the Chicago Medical Society, is ISMS First Vice President **Sheldon D. Schwartz, M.D.,** Deerfield, has been named a fellow of the American College of Physicians **Daniel Gutierrez, M.D.,** Joliet, has been installed as president of the Will-Grundy County Medical Society. Other new officers include **Kenneth Jesunas, M.D.,** president-elect; **Rajendra Shah, M.D.,** vice president; **Amin Khater, M.D.,** secretary-treasurer and **Irving Rudman, M.D.,** secretary-treasurer-elect.

Robert G. Frazier, M.D., Wilmette, has been appointed senior associate dean for academic programs at the Loyola University Stritch School of Medicine. Dr. Frazier succeeds **Anthony Barbato, M.D.,** who has elected to return to full time teaching. Dr. Frazier had previously served as executive director of the American Academy of Pediatrics.

Leon O. Jacobson, M.D., Chicago, is a recent recipient of an outstanding achievement award from the American Society of Contemporary Medicine and Surgery Two Illinois physicians have been named to expert advisory panels of the US Pharmacopeial Convention Committee on Revision. **Arthur L. Herbst, M.D.,** Chicago, will join the Advisory Panel on Endocrinology and **Harold L. Klawans, M.D.,** Chicago, will join the Advisory Panel on Neurological and Psychiatric Disease. The USP has announced that the advisory panels will assume much of the responsibility of their Drug Information Division programs in the next five years.

CHIROPRACTIC CASE APPEALED—Five chiropractors have appealed the antitrust case lost earlier this year against ISMS, the AMA and 11 other co-defendants. The appeal was filed March 2 in the Seventh Circuit Court of Appeals in Chicago. On January 30, 1981, the US District Court jury found all defendants in the suit (*Wilk et al.* v. *AMA, et. al.*) innocent of all charges.

MANAGING YOUR MEDICAL PRACTICE will be the theme of a May 14-15 conference sponsored by the SIU School of Medicine and Sangamon County Medical Society. Conference speakers will discuss computers in medicine, third party reimbursement, malpractice options, tax and estate planning, office facility needs, financial planning, medical records systems, billing and collections and physician advertising. A medical products exhibit is also planned. Targeted to physicians, clinic/office managers, residents, nurses and health administrators, the program will be held at St. John's Hospital in Springfield. Further information may be obtained by writing the Office of Health Systems Research, SIU School of Medicine, PO Box 3926, Springfield 62708; (217) 782-5770.

ANNUAL IPHA MEETING ANNOUNCED—The Illinois Public Health Association will hold their 41st annual meeting April 29-May 1, at the Holiday Inn East, Springfield. "Crisis in Public Health—Policies and Actions," will include seminars on competition in mental health care, legislation, sexual harassment, child abuse and related problems, health needs of the elderly and cancer oncology. Featured speakers will include Gov. James Thompson, who will discuss funding for public health, and U.S. Sen. Thomas Eagleton, (D-MO) who will present a national perspective on public health issues. Non-member registration is $45. For further information contact Dorris Garrett, Illinois Department of Public Health, Division of Health Promotion and Screening, 535 W. Jefferson, Springfield 62761; (217) 782-4733.

WORKMEN'S COMPENSATION PAYROLL AUDITS—Within the next 60 days, field payroll auditors of Casualty Reciprocal Exchange will be calling on those of you who have placed your insurance with that organization. Your cooperation in having the necessary records available for the completion of the audit will be appreciated. The sooner the audits are made, the sooner the Dodson Insurance Group can calculate the earned savings for the past year and make the necessary distribution. If asked to provide a voluntary report instead, you can help materially in reaching an early determination of savings by returning the requested information as promptly as possible.

Illinois Society, American Association of Medical Assistants

Attention ISMS Members

An Idea Worth Pursuing

By Elaine Kaiser, CMA-A President, Illinois Society

One of the goals of the American Association of Medical Assistants, Illinois Society, is to maintain and advance the standards of professional employment and to give honest, loyal and efficient service to the medical profession and the public. We have collaborated with Ingalls Memorial Hospital, Harvey, in establishing an ongoing series of programs with medical staff members' office employees in an effort to develop and maintain a permanent communication vehicle with the hospital. The lecture series is designed to better acquaint physician office personnel with Ingalls Memorial Hospital programs and services, and the procedures to follow for the most efficient utilization of these services.

Monthly lectures beginning in March will cover a wide range of hospital departments and topics of interest and concern. Opportunity for discussion is expected to surface areas of mutual concern for hospital and office medical assistants as well as potential solutions for increased efficiency, communication and integration of office and hospital patient activities.

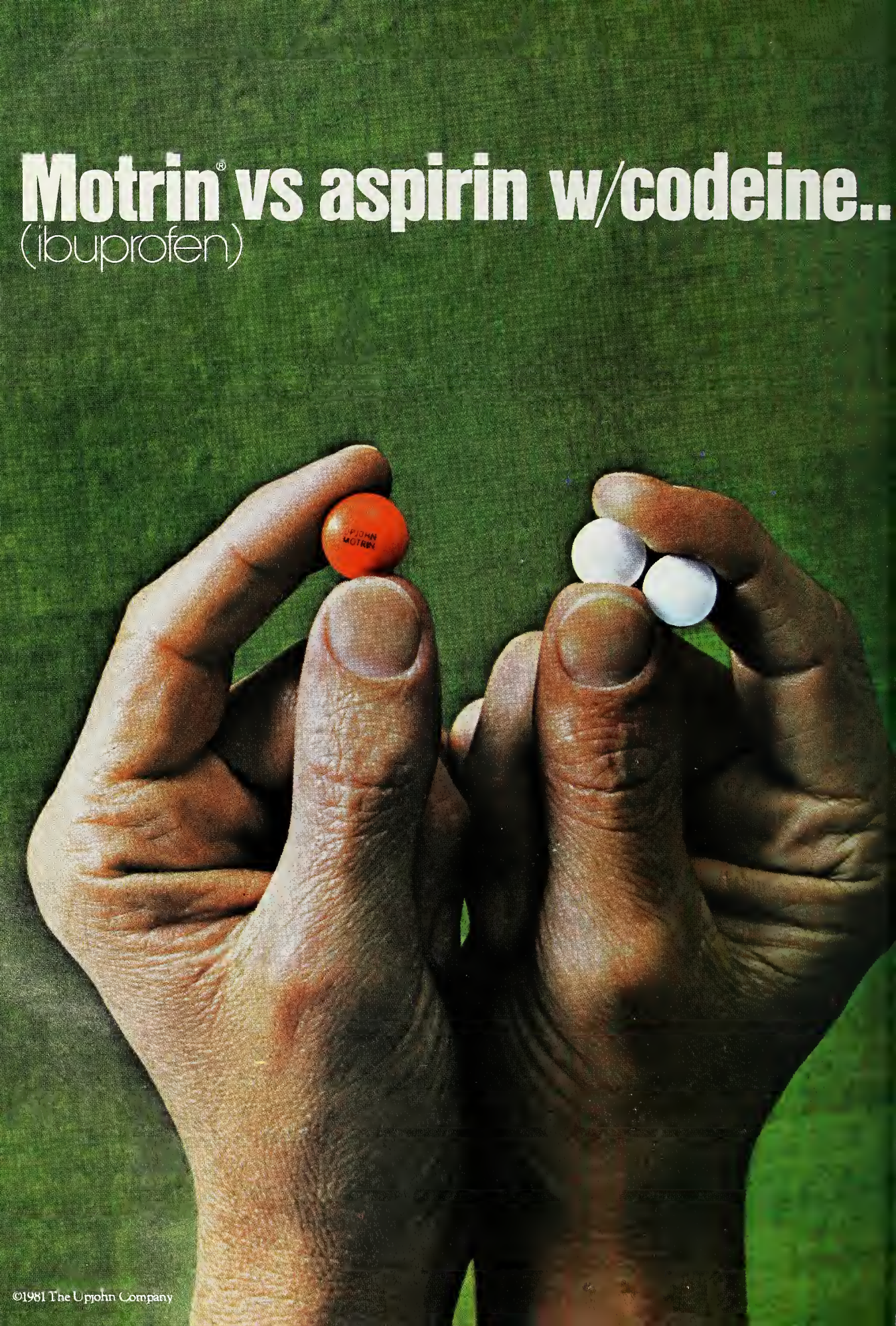
Robert L. Harris, president, stresses that improved relations and rapport are essential to assure a smooth transition in levels of care for our patients. He believes that the lectures and discussions will facilitate that goal.

Physicians' office personnel have often expressed a lack of understanding between the hospital and the physician's office which has not contributed to efficient and effective patient care. Medical assistants with physicians on the staff of Ingalls Memorial Hospital will be given the opportunity to coordinate activities between hospital and office and facilitate better patient care. The integration of office and hospital patient care activities is extremely important in the changing health care delivery system. A well trained medical assistant is one factor in maintaining a smooth running physician's office. The lecture series is designed to assist the medical assistant in a better understanding of her role as an allied health professional. The series schedule includes speakers from the admitting office, patient accounts, medical records, laboratory, radiology, ancillary diagnostic services, community health care, rehabilitation services, social services, administration, patient relations, public relations, alcoholism treatment center, security and communications.

The lecture series will assist medical assistants in reaching the goal of advancing the standards of professional employment and giving honest, loyal and efficient service to the medical profession and the public.

For information regarding AAMA, Illinois Society, contact Elaine Kaiser, CMA-A, president, 9103 Sandpiper Court, Orland Park, Illinois 60462 or Marygrace Sanderson, 501 Heathermead Road, Matteson, Illinois 60443. ◀

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IMJ Attention

LAY MIDWIFE BILL KILLED — House Bills 84 and 171, which would have called for licensure of lay midwives, were heard in the Illinois House of Representatives' Health and Family Services Committee. ISMS opposed this legislation, as in prior years, and HB 171 was defeated in a Committee vote, 14–2. After this defeat, the sponsor of HB 84 decided to table that proposal.

ILLINOIS SENATE COMMITTEES ANNOUNCED — Three committees of the Illinois Senate have responsibility for most health care bills facing the Illinois legislature. New members of each have been announced.

The *Senate Public Health, Welfare and Corrections Committee*, chaired by Steven Nash and vice chaired by William Marovitz (both Chicago Democrats) will include the following Senators: Chicago Democrats Earlean Collins, Glenn Dawson, James McLendon, Dawn Clark Netsch and Richard Newhouse; John J. Nimrod (R-Glenview) minority spokesman; Adeline Geo-Karis (R-Zion); Roger Keats (R-Wilmette) and Jack Schaffer (R-Crystal Lake).

The *Senate Insurance Committee* will be chaired by John D'Arco and vice chaired by Robert Egan, both Chicago Democrats. Membership will include Jerome J. Joyce (D-Essex); Sam Vadalabene (D-Edwardsville); James Rupp (R-Decatur) as minority spokesman; Leonard Becker (R-Cicero); Karl Berning (R-Deerfield); Aldo DeAngelis (R-Olympia Fields); John Friedland (R-So. Elgin) and Chicago Democrats Arthur Berman, Earlean Collins, Glenn Dawson and Walter Negal.

The *Senate Judiciary I Committee* will be headed by Chicago Democrats James McLendon and William Marovitz as chairman and vice chairman. Membership includes Adeline Geo-Karis (R-Zion) as minority spokesman; Prescott Bloom (R-Peoria); Jack Bowers (R-Downers Grove); Frank Ozinga (R-Evergreen Park); and Chicago Democrats Arthur Berman, John D'Arco, Robert Egan, Jeremiah Joyce and LeRoy Lemke.

ILLINOIS HOUSE OF REPRESENTATIVES COMMITTEES ANNOUNCED — Five House Committees hear health-related legislation. In a structural change, Speaker George Ryan has split the former House Human Resources Committee into two separate committees: Health and Family Services and Public Institutions and Social Services.

The *House Health and Family Services Committee* will be chaired by Jane Barnes (R-Oak Lawn) and vice chaired by Glen Bower (R-Effingham). Republican members will be Jesse Jackson, Chicago; Doris Karpiel, Roselle; Steve Miller, Catlin; Roger Stanley, Streamwood; Judy Topinka, Riverside; Sam Vinson, Clinton and Jill Zwick, Dundee. Democratic members, whose spokesman will be Wyvetter Younge, E. St. Louis, will include Chicagoans Woods Bowman, Alfred Ronan and Jessie White; Gary Hannig, Mt. Olive; Jim Rea, Christopher and Mike Slape, Pocahontas.

The *House Judiciary I Committee* chairman is Harry Leinenweber (R-Joliet). The vice chairman for the committee will be Timothy Johnson (R-Urbana) and the minority spokesman is Aaron Jaffe (D-Skokie). Judiciary I Committee membership includes Republicans David Barkhausen, Waukegan; Edward Bluthardt, Schiller Park; Patrick Grossi, Glenwood; John Hallock, Rockford; Jeffrey Mays, Quincy; Judy Topinka, Riverside and Sam Vinson, Clinton. Democratic membership includes Peg Breslin, Serena; Richard Brummer, Effingham; Michael Getty, Dolton and Chicagoans John Beatty and John Cullerton.

Elroy Sandquist (R-Chicago) will chair the *House Registration and Regulation Committee*, assisted by vice chairman Frank Watson (R-Greenville). Republican members include Chicagoans Phillip Bianco and William Margalus; Emil Boucek, Western Springs; Jack Davis, Beecher; John Hallock, Rockford; Josephine Oblinger, Springfield and Everett Steele, Glen Carbon. Democratic spokesman Marco Domico, Chicago, will be joined by Democratic members Richard Mautino, Spring Valley; John O'Connell, Western Springs; Joe Ozella, Pekin; Greg Zito, Melrose Park; and Chicago members Robert Krska and Myron Kulas.

Susan Catania, Chicago, will act as chairman of the *House Public Institutions and Social Services Committee*, assisted by vice chairman Josephine Oblinger, Springfield. Other Republican members are Suzanne Deuchler, Aurora; Jack Dunn, Tinley Park; Virginia Frederick, Lake Forest; Dolly Hallstrom, Glenview; Judith Koehler, Henry; Frank Martire, Chicago and Michael Tate, Decatur. Democratic members are minority spokesman Helen Satterthwaite, Urbana, and Chicagoans Barbara Currie, William Henry, Ellis Levin, Lee Preston, Sylvester Rhem and Margaret Smith.

The *House Insurance Committee* will be chaired by Bernard Epton, Chicago and vice chaired by John Birkinbine, Northfield. Chicago Republicans on that committee are William Margalus, Elroy Sandquist and Ronald Stearney. Other Republicans are John Ackerman, Morton; Edward McBroom, Kankakee; Diana Nelson, Western Springs and Calvin Schuneman, Prophetstown. Democrats on that committee, whose spokesman is Daniel O'Brien, Chicago, are Richard Brummer, Effingham; Douglas Huff, John Vitek and Arthur Turner, Chicago; Sam Wolf, Granite City. One Democratic slot remains open.

MORE THAN $2 BILLION IN HEALTH PROGRAM CUTS PROPOSED — The AMA has reported that President Reagan's formal budget calls for health program cuts exceeding $2 billion, including a proposed cap of federal Medicaid payments and a 25% reduction in the federal contribution to health and welfare programs. The budget proposes that the federal health planning program and PSRO be eliminated, spending for HMOs be phased out by 1983, seven CDC programs be eliminated and capitation grants for health professions education be abolished. Congressional committee hearings and formal actions will be updated as available.

PATIENT PACKAGE INSERTS — AMA reports that HHS Secretary Richard Schweiker has stayed implementation of the FDA's final rule requiring PPIs on certain drugs, in order to "re-examine the cost-effectiveness of the PPI concept."

In another rescission, the Office of Management and Budget has deleted its December, 1980, requirements for policies and procedures to limit federal financial support for hospital construction in "overbedded areas." That proposal would have removed federal dollar support for hospital development in such areas absent an HHS-approved hospital facilities plan to reduce "excess bed capacity."

MEDICINE GETS A GREATER VOICE — AMA reports that planned reorganization of the Department of Health and Human Services would elevate the position of assistant secretary for health to undersecretary. The president has nominated Edward N. Brandt, Jr., M.D., vice chancellor for health affairs at the University of Texas, to serve as undersecretary. Dr. Brandt is chairman of the AMA Section on Medical Schools and serves on a number of AMA committees.

RESPONSES TO AN AMA SURVEY in February indicate that 77% of physicians responding experienced a faster rate of increase in expenses than income in 1980. Salaries and wages to employees, utility costs, rent increases and operating expenses were cited as primary causes.

INTERNATIONAL CARDIAC TRANSPLANTATION SOCIETY FORMED — A new organization to maintain data on human heart transplants and help surgeons improve techniques and lengthen survival time has been formed through the American College of Cardiology.

Blue Cross® Blue Shield®

REPORT FOR *Illinois Physicians*

BLUE CROSS AND BLUE SHIELD ASSOCIATIONS ACT TO SPUR SUBSCRIBER USE OF AMBULATORY SURGERY

The Blue Cross and Blue Shield Associations have announced a nationwide effort to encourage increased subscriber use of ambulatory surgery as a substitute for expensive inpatient surgery where appropriate.

This effort is in response to the problem of rising health care cost.

The Associations recommended in a new policy statement that their 110 Member Plans, which pay hospital and medical bills for nearly one out of two Americans, adopt "action plans" to implement and promote the use of ambulatory surgery programs in the least costly manner consistent with quality of care.

Some 21 million inpatient surgical procedures are performed annually at a cost of more than $30 billion, or about $1,500 per inpatient procedure on the average. With elimination of room and board charges, costs for ambulatory or same-day surgery could run as much as 30 to 50 per cent less than inpatient surgery.

"We stand behind the concept that surgery, like any other health service, should be performed in the least expensive setting that enables delivery of safe, high quality care," said Walter J. McNerney, president of the Associations.

Advantages of same-day surgery cited by McNerney, include a reduction in the waiting period for surgery, the convenience to both patients and physicians, a moderation in psychological trauma and apprehension for patients, especially children, and the benefit of recovery and recuperation in the home setting with less time lost away from family and job.

McNerney said the Associations are confident that major professional and institutional organizations can be supportive of the new ambulatory policy.

"Blue Cross and Blue Shield Plans should work to contain the total cost of health care, not just costs of individual surgery cases," McNerney emphasized. "While reducing the cost of surgery for an individual patient in a particular setting is important and contributes to cost containment, equally important are the savings associated with the introduction of new efficiences in hospital operations, changes in surgical care capacity and positive steps to reinforce sound physician practice patterns."

According to the Associations, five of the most frequently performed inpatient surgical procedures that can often be handled without hospitalization—biopsies, dilation and curettage (primarily diagnostic), tubal ligations, tonsillectomies and adenoidectomies, and hernia repairs—account for about one-sixth of all inpatient surgical procedures performed, or a total of more than 3.4 million annually.

McNerney said hundreds of surgical procedures can be performed safely and efficiently on an outpatient basis, and many physicians have made use of this technique for many years.

ILLINOIS BLUE CROSS AND BLUE SHIELD PLAN A PIONEER IN PROMOTING AMBULATORY SURGERY

The Illinois Blue Cross and Blue Shield Plan is in full support of the Blue Cross and Blue Shield Associations' effort to encourage the use of ambulatory surgery as a means of containing health care costs.

In a recent letter to health care leaders, Richard C. Shaw, M.D., Vice President-Medical Director, and Jon Shattuck, Vice President-Hospital and Provider Affairs, said "our plan has been a leader in promoting the development and utilization of ambulatory surgical facilities in Illinois.

"Our plan also was a pioneer in providing benefits for surgery performed in outpatient settings," they point out.

To assist hospitals and physicians in encouraging utilization of this alternative to inpatient care, the Plan has prepared a list of surgical procedures which the surgical community agrees usually can be performed in an ambulatory setting.

Dr. Shaw and Shattuck emphasized that "this is not meant to be an exhaustive, or all-inclusive list of procedures. It does, however, include procedures for which patients are still frequently hospitalized.

They strongly urged "a close examination of ambulatory surgery programs and policies. We also ask that surgical staffs be encouraged to perform these procedures and other surgical procedures, whenever appropriate to a patient's care, on an out-patient basis."

Dr. Shaw and Shattuck said they would be interested in learning if hospitals perform outpatient surgery for procedures not listed and would like to be notified of these procedures, so that the information can be shared with others.

The following are selected surgical procedures generally considered appropriate for ambulatory surgery:

Abdominal paracentesis
Abortion, first trimester
Antrum irrigations
Arthrocentesis
Arthrography and arthroscopy
Aspiration of Douglas's cul-de-sac
Bartholin cyst excision, marsupialization or I&D
Bladder puncture aspiration
Blepharoplasty, non-cosmetic
Breast biopsy
Bronchoscopy with or without biopsy
Carpel tunnel
Cervical biopsies or polypectomies
Circumcision, male
Closed reduction of complete dislocations or fractures
Culdoscopy with or without biopsy
Cyst aspiration
Cystogram
Cystoscopy with or without retrograde pyelogram
Digit amputation
D&C, diagnostic and therapeutic
Dorsal split of prepuce
Esophageal dilation
EUA (examination under anesthesia)
Excision of soft tissue lesions (nevus, verrucus, epithelioma, scar revision)
Fiberoptic endoscopy with or without biopsy
Foreign body removal
Frenulotomy of tongue
Full bone impacted teeth
Ganglionectomy
Gastroscopy with or without biopsy
Herniorrhaphy (up to age 14)
Hydrocelectomy
Hymenectomy
Hysterosalpingography
I&D (incision and drainage of superficial lesions)
Ingrown toenail removal
Injection of joint, tendon or ligament
IUD insertion and removal, if anesthesia necessary
Kidney needle biopsy
Laceration suture of skin and tendons
Laparoscopy with or without tubal ligation
Laryngoscopy with or without biopsy
Lipoma removal
Liver needle biopsy
Lumbar puncture
Mammoplasty, non-cosmetic
Meatotomy
Minor eyelid procedures
Minor rectal surgery (not under spinal)
Morton's neuroma
Muscle biopsy
Myringotomy
Nasal fracture reduction, open and closed
Nasal Polypectomy
Nerve blocks
Node biopsy (superficial)
Otoplasty, non-cosmetic
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Proctosigmoidoscopy with or without biopsy
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Tear duct probing
Thoracentesis for fluid aspiration
Trigger finger
Triple upper endoscopy
Urethral dilation
Varicocelectomy
Vasectomy
Vein sclerosing injection
Venography

IMJ

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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

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Abstracts of Action

April 4-8 **Chicago**

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

MEDICAID

ISMS will oppose IDPA's plan to require second opinions for selected surgical procedures covered by Medicaid. The second opinion program is among several steps planned in an effort to cut $78 million from IDPA's Fiscal '82 budget. Gov. Thompson has called for major budget cuts in all phases of State government. ISMS will urge the Department to rely upon its existing peer review process to curb improper utilization.

In related action, the Board voted to provide financial support for the appeal of a suit challenging IDPA's use of extrapolation during on-site fiscal audits. After reviewing a small percentage of claims, IDPA employs extrapolation to determine the alleged amount of overpayment. In a suit filed by Dr. Elsy Salazar, Chicago, a circuit court ruled extrapolation was permissible. Dr. Salazar is appealing the decision. ISMS had provided financial assistance for the challenge at the trial court level.

ILLINOIS DEPARTMENT OF MENTAL HEALTH

ISMS will voice concern to Gov. Thompson and the Governor's Commission on the Mental Health Code over problems in mental health care caused by the recently-imposed freeze on hiring state employees. The Society will note that insufficient personnel are available to handle IDMHDD's rising patient census, thereby jeopardizing the provision of care as intended and needed in state facilities.

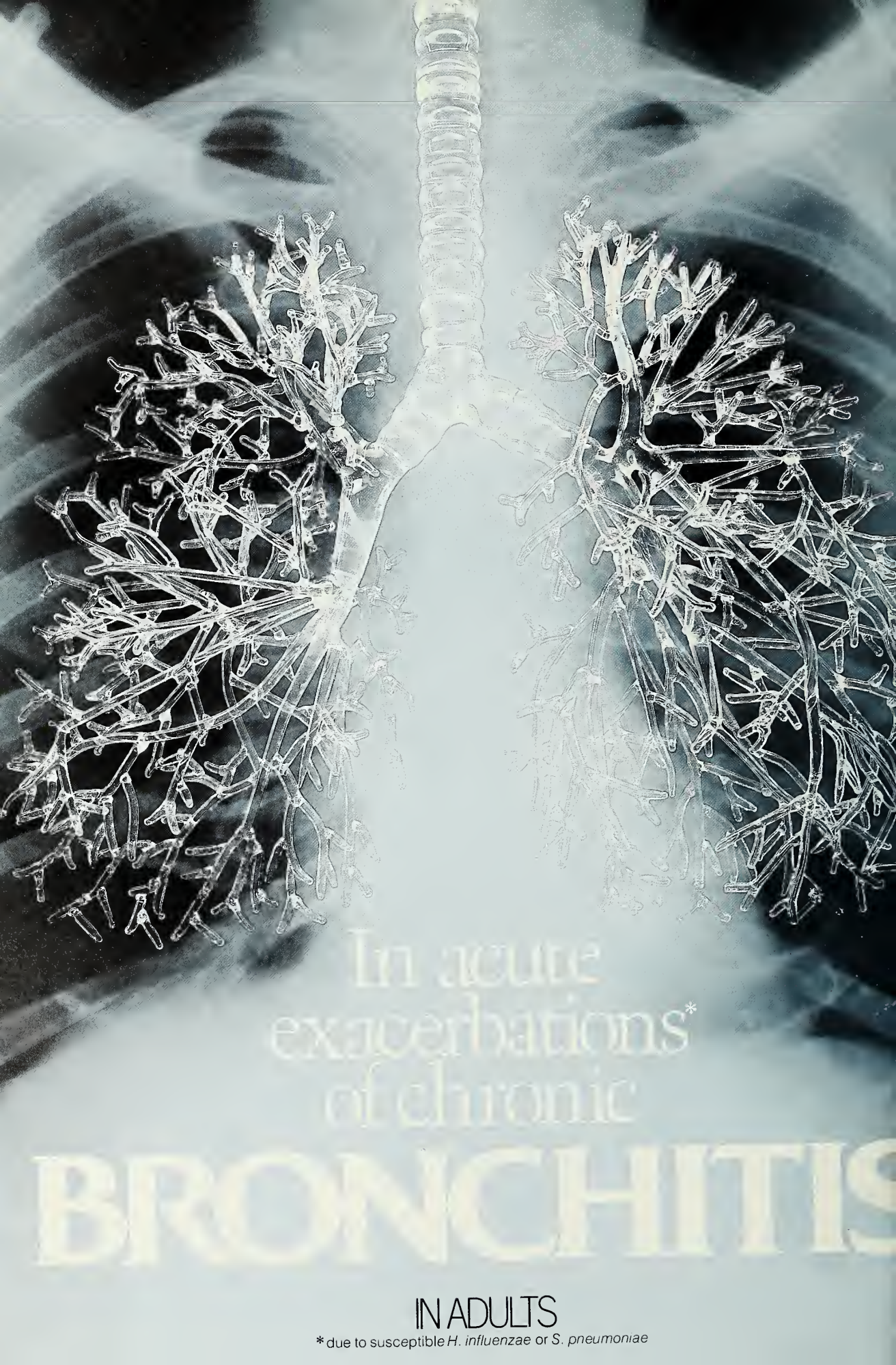
LEGISLATION

The Board approved the draft of a legislative proposal—for introduction in the current General Assembly session—that would extend "Good Samaritan" protection to a physician who responds in a hospital to a "code blue" or life-threatening situation, provided: (1) He is not compensated for his assistance; and (2) Such activities are not part of his normal duties. ISMS also will begin development of legislation that would define informed consent.

SPECIAL PROGRAMS

Acting on requests concerning special programs, the Board voted to:

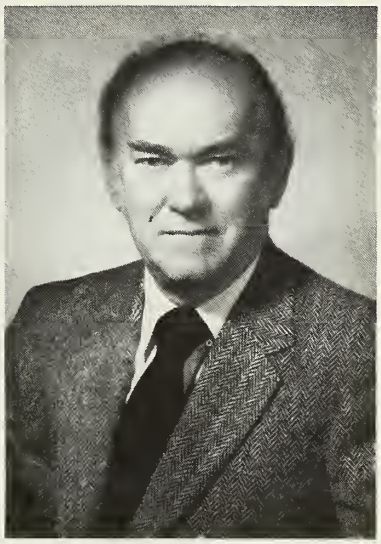
- Approve the script for an educational slide presentation on HMOs and IPAs that will be made available to county medical societies. The project is being developed under a grant from the Foundation for Medical Care of Central Illinois.
- Seek a grant—through the ISMS Educational and Scientific Foundation—from the Dangerous Drugs Commission to support a continuing program aimed at equipping correctional officers to handle chemically-dependent inmates. The educational effort is part of the ISMS-sponsored Illinois Jail Health Program.
- Co-sponsor—with the Governor's Task Force on the Fetal Alcohol Syndrome—a clinical workshop on the fetal alcohol syndrome, June 17, at the University of Illinois Chicago Circle Center, Chicago. ISMS will assist in program promotion, with expenses covered under an existing grant from the IDMHDD Division of Alcoholism.
- Conduct a multi-faceted campaign to educate the public on the dangers of alcoholism. The campaign will be financed by a grant from the IDMHDD Division of Alcoholism. The Society also will use grant monies to distribute to all members information on the Panel for the Impaired Physician and the availability of a Speakers Bureau on alcoholism education. *(Continued on page 318)*



IN ADULTS

*due to susceptible *H. influenzae* or *S. pneumoniae*

President's Page



Pursuing The 'Greater Good'

Editor's Note: The following is an excerpt from Dr. White's inaugural address presented to the ISMS House of Delegates April 7.

The medical profession and this organization face a changing situation. In a society as alive and dynamic as ours, change is the only constant.

In recent years, there have been threats to the practice of medicine, challenges to our profession, and changes in the political and economic climate. We again face this triad of change, threat and challenge. Traditionally, the profession has responded with varying degrees of success. But we have learned a great deal from these experiences.

The challenge now confronting us is rooted in the abrupt change in governmental direction. We may find ourselves, as small businessmen, pleased that lessening regulation is "getting government off our backs," but disturbed, as recipients of government dollars, that there is less funding available.

As men and women of science trained in the scientific method, we have the tools and ability to meet the challenges. Societal and economic data must be analyzed in the same non-emotional manner as scientific data. New approaches suggested by society must be tested in the same cautious and calculated manner we employ to check a new procedure or therapeutic regimen. And we must exercise our judgment to identify appropriate utilization of acceptable methodology. New systems or methods of delivering care must not be rejected simply because they are new or different. To do so would be contrary to our professional heritage and responsibility.

Professionally, and as an organization, we have learned the importance of involvement in the process of societal decision making, and have had a significant impact on the legislative process. We have learned to negotiate with governmental agencies, and continue to act responsibly and credibly in that area. Physicians are reasonable problem solvers. This is consistent with our professional heritage and mission, and will extend well into our future areas of need.

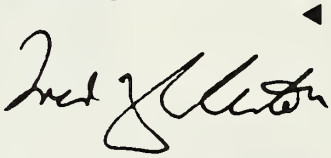
One of a profession's most striking needs is to have autonomy and control over its members and their actions. Only physicians have the competence and skill to capably judge other physicians. Since we cannot accept the judgment of others, we must accept the responsibility to review and pass judgment on those whose activities are questioned. This is a heavy responsibility, but it is ours alone. To protect those who place self-interest above service to the public and patients is to demean the profession.

Our effectiveness undeniably is tied to our strength. Unfortunately, organized medicine, with its many organizations, is in jeopardy of becoming disorganzied. Unified membership is fading. Specialty societies, medical schools and various economic groupings all clamor to speak for their special and specific interests. The outcome of that process, if carried to its ultimate conclusion, only can be confusion—not a clear voice. In Illinois, the profession's clear voice can, and should, come from ISMS.

As a medical association, we must be concerned with the "greater good." What may be ideal for one group of physicians may be detrimental to the larger portion of our medical society. Conversely, what is generally good for the Society will, to varying degrees, be good for all segments of medicine. Our concern must be for that "greater good" of the Medical Society and an extension of the "greater good" to our overarching public society. We must concentrate on common goals, not minor differences.

To aid us in that effort, goals and attainable objectives have been developed for ISMS. They are only a beginning, and will be improved and refined. Like all goals, they will be a moving target. But they are something to aim at.

This goal setting should enable us to focus on common objectives and avoid being distracted by our differences. We must keep in mind that what is best for society as a whole will be best for us as a profession, as a medical organization, and as individuals. ◀



Fred Z. White, M.D., President

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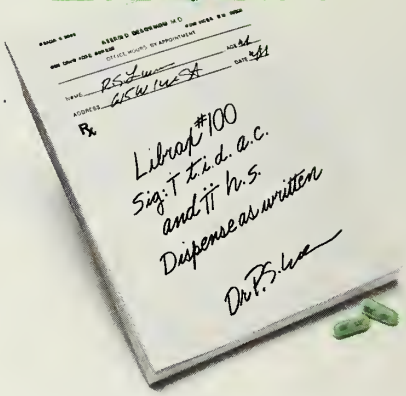
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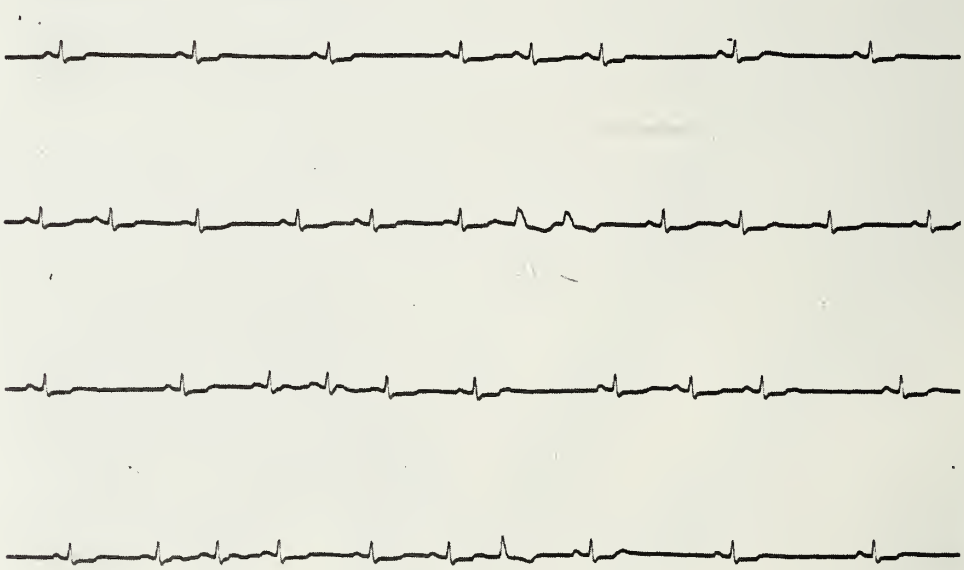
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EKG of the Month

Contributing Editors: John F. Maran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlan, M.D., Sarah A. Johnson, M.D., John R. Tabin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a sixty year old man who presents for evaluation because his pulse seems slow and he feels lightheaded. He denies syncope, chest pain, dyspnea, and ankle swelling. His past medical history is non-contributory. He is taking no medicines. His physical exam is normal except for an irregular heart beat. A chest X-ray is normal. A long single channel ECG rhythm strip is shown.



Questions:

1. **The ECG rhythm strip shows:**
 - A. Intermittent sino-atrial block.
 - B. A pair of premature ventricular beats.
 - C. Intermittent marked sinus bradycardia.
 - D. Premature atrial beats, conducted and non-conducted.
 - E. Aberrant intraventricular conduction.

2. **The following statements are true:**
 - A. Premature atrial beats can occur in normal as well as diseased hearts.
 - B. Premature atrial beats can often lead to other atrial arrhythmias.
 - C. If the patient were in congestive heart failure and had premature atrial beats, digitalis could treat both problems.
 - D. Quinidine is a useful treatment for premature atrial beats.
 - E. All of the above.

(Continued on page 324)



"EVERY AGE HAS ITS PLEASURES, ITS STYLE OF WIT, AND ITS OWN WAYS."

—from *The Art of Poetry* (1674) by Nicholas Boileau-Despréaux

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6/80

Doctor's News

PHYSICIANS IN THE NEWS—Newly elected to join the Illinois State Medical Inter-Insurance Exchange Board of Governors are **Alfred Kiessel, M.D.,** Decatur and **James Mason, M.D.,** Evanston. Re-elected as chairman and vice-chairman were **Robert R. Hartman, M.D.,** Jacksonville and **Julian Buser, M.D.,** Belleville. Re-elected Board members were **Allan Goslin, M.D.,** Streator; Fredric Lake, M.D., Evanston; **Henri Havdala, M.D.,** Lincolnwood; **Brent Horsley, M.D.,** Rockford; **Kenneth Hurst, M.D.,** Naperville; **Ross Hutchison, M.D.,** Gibson City; **Eugene Johnson, M.D.,** Casey; **David Littman, M.D.,** Glencoe; **Grover Sloan, M.D.,** Carrier Mills; **Irwin Smith, M.D.,** Northbrook; **Fred Z. White, M.D.,** Chillicothe; **Charles Williams, M.D.,** Springfield and Chicago physicians **David S. Fox, Morris T. Friedell, Lawrence L. Hirsch, Walter Whisler** and **Cyril C. Wiggishoff.**

Newly elected medical staff officers for Louis A. Weiss Memorial Hospital in Chicago are **Robert D. Keagy, M.D.,** president; **Irving Savin, M.D.,** vice president; **Paul Saltzman, M.D.,** secretary and **David Swarner, M.D.,** treasurer Newly elected medical staff officers at Riveredge Hospital in Forest Park are **James A. Gibson, M.D.,** president; **Nicholas J. Borden, M.D.,** president-elect; **Rosa Abraira, M.D.,** secretary and **Boniface Dy, M.D.,** treasurer.

Newly elected president-elect of the Society of Thoracic Surgeons is **Hassan Najafi, M.D.,** Northfield. Dr. Najafi is a professor of surgery and chairman, department of cardiovascular-thoracic surgery at Rush-Presbyterian-St. Luke's Medical Center.

William Sherrick, M.D., has assumed the post of president of Memorial Medical Center, Springfield. Dr. Sherrick is a member of Memorial's radiology staff **Norman Hugo, M.D.,** Chicago, was recently elected secretary of the American Society for Aesthetic Plastic Surgery, Inc. Dr. Hugo is an associate professor of surgery at Northwestern University Medical Center and attending surgeon at Children's Memorial and Northwestern Memorial Hospital Newly elected medical staff officers at Grant Hospital in Chicago are **Hans W. Schlecht,** president; **Jesus G. Vega, M.D.,** vice president; **Ludwig Kaminski, M.D.,** treasurer and **Raymond W. Petkus, M.D.,** secretary.

ILLINOIS INSTITUTE ON DRUG ABUSE SCHEDULED—The Illinois Dangerous Drugs Commission will sponsor the second annual statewide drug studies program on June 1-5 at Millikin University, Decatur. Continuing education credit for nurses, undergraduate and graduate students is available through the Illinois Nurses Association and Governor's State University. The institute seeks to transfer information and skills among individuals working with substance abusers or potential abusers. Registration is available by writing IIDA-81 Planning Committee, Attention: Carmen Townsend, Illinois Dangerous Drugs Commission, 300 N. State, Suite 1500, Chicago 60610. A sliding scale of registration fees for partial to full participation in the conference is available from DDC.

ERRATA—Some incorrect information was published in the author background summaries for "Laboratory Diagnosis in Thyroid Disease," by Vincent Lopez-Majano, M.D., and Carlos Abraira, M.D., in the February *IMJ.* Doctor Lopez-Majano's posts, chairman of the Cook County Hospital Nuclear Medicine Division and also clinical associate professor of medicine at the Chicago Medical School, are current, *not* former positions. Also, Dr. Abraira, whose biographical note stated that he was chief of the department of medicine, Michael Reese Hospital, is presently chief, Endocrinology Section, Hines Veterans Administration Hospital. We apologize for these errors.

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Guest Editorial

A Proposal For Health Care Policy

By Robert J. Becker, M.D./Joliet

In the 1930's, medical care was of concern to the patient, his/her family, and their family physician.

In the 1930's, medical care was 95% art and 5% science. The number of specific cures for diseases could be counted on two hands. Surgical procedures were frequently the "court of the last resort."

In the 1930's, people generally considered that hospitals were places that people went to die. As a result, patients went to hospitals unwillingly and often with little anticipation of a bright outlook upon discharge.

In the 1980's, medical care is still of concern to the patient, his/her family and their family physician. It is also of concern to the patient's employer, the insurance carrier, and at least three consultant physicians who are seeing the patient. It is of concern to the local PSRO, the local HSA, and the patient's labor union, just to mention a few of the concerned parties.



ROBERT J. BECKER, M.D., is an allergist and immunologist, in Joliet. Board certified by the American Board of Allergy and Immunology, he is also part-time medical director for the Quad River Foundation for Medical Care. Dr. Becker is executive vice president of the Joint Council of Allergy and Immunology. He is a member of the ISMS House of Delegates, current president of the American Association of Professional Standards Review Organizations, and a fellow of both the American College of Physicians and the American Academy of Allergy.

In the 1980's, medical care is 85% science and 15% art (percentages vary with the level of care and perspective of the viewer). There are specific drugs which provide specific cures for diseases and specific cures for diseases caused by specific drugs.

In the 1980's, people go to hospitals for diagnostic workups, for therapeutic rests, and for specific treatments for diseases not even known in the 1930's.

From a small humanitarian industry involving a small percentage of the population, health care has grown to be the second largest industry in this country. It now costs approximately 11% of the Gross National Product.

The forces which have been responsible for the changes in medicine and medical care in the past 50 years must be examined if the people of this country are to profit and not suffer from these advances.

What are some of the forces, how can they be addressed and controlled, and by whom?

Scientific Forces

The scientific knowledge explosion has probably been the central force for change. This knowledge explosion resulted in development of antibiotics, manipulations of chemicals, proliferation of nuclear medicine into health care, development of new and safer surgical techniques, and numerous other health care technological advances.

The secondary effect of this knowledge explosion was the development of medical and surgical specialties and subspecialties. No longer could one family physician know all about everything. The development of the specialist who knew more and more about less and less was inevitable. The resultant increase in contact of patients by increasing numbers of M.D.s then became a necessity. This growth in medical technology has not reached its limits, nor should it be

restricted from growing and becoming more necessary to improve the quality and length of life.

Economic Forces

As health care became more scientific, it became more costly. Something had to be done to insure its availability and ensure the ability of the patient to pay for it. Insurance coverage was therefore a natural evolution. Initially, it was available on a private basis. Such coverage then became of concern to labor unions and industry as a "fringe benefit". The patient then regarded such medical care as "free" and felt that physicians, nurses, and other professionals should solve all their health care problems. One must also recognize that this economic force created a whole new work force, which became part of the health care industry. (Great numbers of hospital personnel, insurance companies, administrators, salesmen, review personnel, employee and labor benefits people, etc.)

The second economic force generated by the scientific explosion also resulted in the social awareness that two segments of the population had difficulty paying for this now expected health care——the people over 65 and the indigent. That economic force resulted in the passage of Medicare and Medicaid legislation in 1965.

Today

This brings us to today. At the present time, we have the following:

1. Patients expect that their illnesses will be promptly treated and cured. Patients have no incentives to decrease utilization. The mustard plaster, "Vicks" chest rub, a vaporizer, aspirin, and fluids as treatment for the common cold are no longer reasonable. There is now the need for antibiotics, decongestants, in addition to blood counts and chest X-rays and multiple sophisticated tests to rule out pneumonia or some other unanticipated disease.
2. Physicians and other health providers want to provide maximum medical benefits and want to determine the cost of such care. They feel threatened by a society in which one of the early thoughts of an unhappy patient is to sue the physician for malpractice. They also feel insecure if external factors are threatened or exerted to contain the cost of their care.
3. We have expensive hospitals with expensive equipment, sophisticated technology and beds which must be filled to pay for the expensive equipment, the sophisticated technology and the many beds.
4. We have an exploded bureaucracy created to monitor the care provided to the patients, the cost for such care and the drugs, devices, and the technology used in that care.
5. As a result, we also have a segment of the country which believes a health care monster has been created that must be controlled in the fashion most acceptable to bureaucrats—create another bureaucracy.

Having broadly delineated the problems, let me broadly delineate the principles of the solutions:

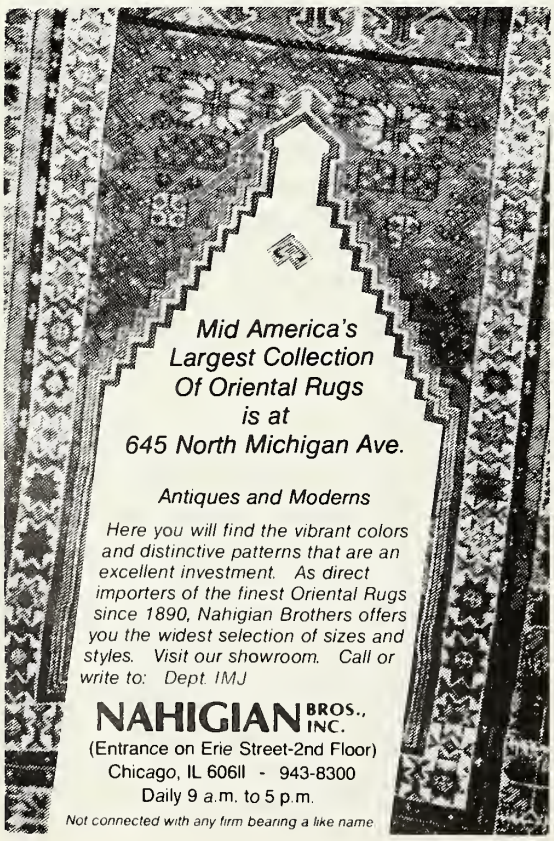
1. Health care should be accessible to everyone. Its accessibility should be in keeping with the principles of private enterprise—freedom of choice to the greatest extent possible.
2. Incentives should be created for patients and physicians to decrease the utilization of the health care delivery system. Multiple choices of delivery systems should be encouraged; i.e., service benefits insurance programs, IPAs, HMOs, as well as continued private fee for service. Physicians must always fulfill the role of maintaining quality assurance as health care delivery systems become more concerned with costs than with quality of care.
3. The health care profession has the structure and design to constructively peer review the quality and cost effectiveness of health care provided.

 A mechanism has been initiated which should be able to address this issue. This mechanism was implemented by PL 92-603 and is called Professional Standards Review Organizations. These should be considered as an unusual, locally controlled, decentralized "marriage" of government and the medical profession. They do create the mechanism for local control of health care if physicians are only willing to accept such responsibilities. Unfortunately such perception and willingness has not occurred to a great enough extent, at least at the present time. Physicians now stand the real risk of losing this control to non-physicians.
4. Capital expenditures of health care facilities is another area already addressed by PL 93-641. The health planning act does provide a mechanism for controlling such capital expenditures. A careful balance is needed between preventing unnecessary capital expenditures and stifling the ability of these facilities to efficiently and effectively provide facilities in keeping with technological advances. The fate of this mechanism now is in limbo, awaiting fiscal decisions by the Reagan administration. Some control of capital expenditures of health care facilities is and will always be necessary.
5. Private enterprise (business and labor) should

continue to insist that the private sector continue and expand insurance coverage within the constraints previously mentioned.

6. The medical profession must stop demanding the continuation of status quo but must address the cost and quality issues that are within its own purview. It must vigorously recognize its responsibilities in effecting constructive change and not exert its energies digging its heels into its turf to retain the "status quo."
7. All segments of the society must accept the fact that preventive medicine is cheaper than therapeutic medicine and is *everyone's responsibility.*

The solution of the health care system problems will not occur with a National Health Insurance Program but lies in the hands of patients, physicians, industry, unions, and government who are interested and dedicated to solving the personnel problems by private enterprise in the private sector. ◀



Brief Summary

INDICATIONS — For management of anxiety disorders or short-term relief of symptoms of anxiety. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use (over 4 months) not assessed by systematic clinical studies. Physician should periodically reassess usefulness for each patient.

For symptomatic relief of acute alcohol withdrawal.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 18. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

DOSAGE — ANXIETY — Usual daily dose 30 mg or less (start the elderly or debilitated at 7.5-15 mg). Adjust gradually within 15-60 mg daily range. Capsules and scored tablets: divided doses; or once daily h.s. (start patient at 15 mg). Single dose tablets, 22.5 mg (for patients stabilized on 7.5 mg t.i.d.) or 11.25 mg: once daily at any hour.

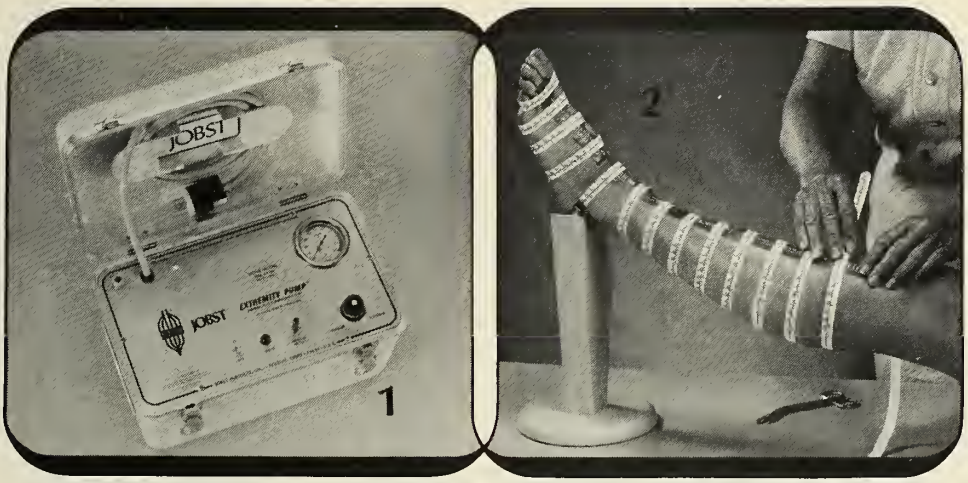
INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE — Take general measures as for any CNS depressant.

SUPPLIED — Tranxene (clorazepate dipotassium) 3.75, 7.5, and 15 mg capsules and scored tablets. Tranxene-SD Half Strength 11.25 and Tranxene-SD 22.5 mg single dose tablets.

REFERENCES — 1. The elimination kinetics of an agent can be closely defined, but cannot at present be directly related to therapeutic or adverse effects. 2. Sedation reported in normal volunteers 30 minutes after dosing. TRANXENE Drug Monograph 97-0185, 1979, p. 9. 3. Op cit., p 15.

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June 17, 1981

Fetal Alcohol Syndrome Conference Announced

The third annual Fetal Alcohol Syndrome Conference has been scheduled for June 17, 1981, at the University of Illinois Chicago Circle Center. For the third year, ISMS has joined the Governor's Citizens Advisory Council on Alcoholism, Lutheran General Hospital, MacNeal Memorial Hospital, Chicago Health Systems Agency, Illinois and Chicago Associations for Retarded Citizens, Illinois Nurses Association and UI School of Nursing, in co-sponsoring the event.

The program will be held from 8:30a.m. to 4:30p.m., and hour-for-hour Category 1 CME credit will be awarded to participants. Cost of attendance is $35, which includes lunch and all materials. The workshop is intended to increase awareness and knowledge of the fetal alcohol syndrome and provide intervention skills for physicians, nurses and other health professionals.

Specifically, the conference will seek (1) to educate about the effects of alcohol on the unborn; (2) to foster awareness in identifying women of child bearing age at risk from alcohol and to provide information relative to their special treatment needs; (3) to provide information to physicians, nurses, and other clinicians on appropriate intervention strategies for counseling pregnant women; (4) to provide information that will help identify and treat the child with Fetal Alcohol Syndrome and (5) to provide updates on the research being conducted on Fetal Alcohol Syndrome.

ISMS members who have attended the FAS Workshop in prior years strongly support this effort. Further information may be obtained by contacting Ms. Emma Redmond or Mr. Maurice Lyons, Division of Alcoholism, IDMHDD, 160 N. LaSalle, Room 1500, Chicago 60601; (312) 793-2907.

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Roentgenographic Manifestations of Diverticulitis

By Richard M. Gore, M.D. and Leonid Calenoff, M.D./Chicago

About 10% of the adult population in this country older than 40 years of age has colonic diverticulosis, a stigma of the western man and his low fiber diet.[1] About 20% of patients with diverticulosis will eventually develop diverticulitis. Clinical and roentgenographic manifestations of diverticulitis are often deceptive and may simulate such gynecological problems as pelvic inflammatory disease and endometriosis, medical problems like inflammatory bowel disease and surgical conditions such as appendicitis or carcinoma.

In recent years, the concept of diverticulitis has undergone several fundamental modifications. Rather than mere inflammatory obstruction of a diverticulum, it is now generally accepted that diverticulitis represents a microscopic or macroscopic perforation of a colonic diverticulum.[2] This perforation can occur acutely secondary to a sudden rise in colonic pressure, or sub-acutely through a stage of stretch ischemia and ulceration. The perforation produces a spectrum of inflammatory changes ranging from localized abscess formation to massive peritonitis.[3] Perforation with free air is uncommon because the diverticula point toward the taenia mesicolica, an area rich in pericolonic fat. Microperforation, however, will produce an abscess in the same pericolonic fat, a localized abscess or massive peritonitis. When a microperforation occurs, there may be a focal area of inflammation or abscess formation at the site of the perforation. As this abscess extends, fistula may track along the bowel wall, to the abdominal wall or into a nearby organ (most frequently the urinary bladder). Clinically, the patient may present with findings of a pelvic inflammatory disease, genitourinary problems or appendicitis.

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Leonid Calenoff, M.D. is professor of radiology, Northwestern University Medical School and chief, Outpatient Diagnostic Radiology, Northwestern Memorial Hospital and The Rehabilitation Institute of Chicago.

Roentgenographic Manifestations

The roentgenographic criteria necessary to es-



Figure 1
Longitudinal sinus tract **(arrows) seen in the sigmoid colon on the post evacuation film from a barium enema in a 69 year-old woman with diverticulitis.**

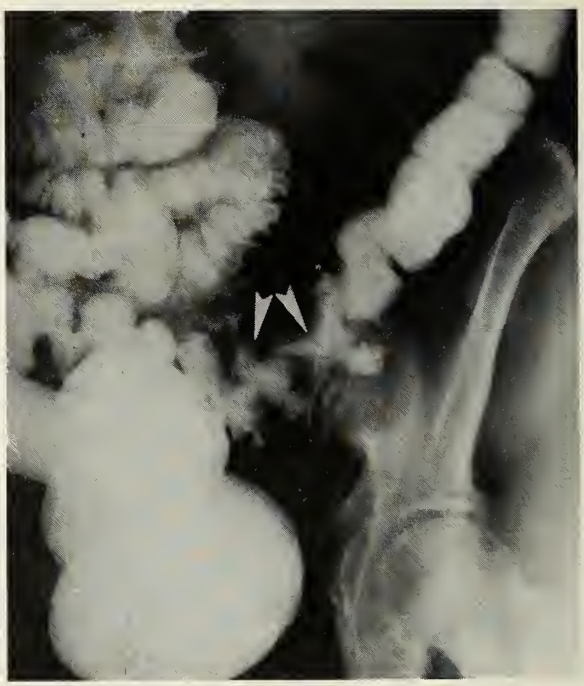


Figure 2
Cushion defect **(arrowheads) present on a barium enema in a 52 year-old male with diverticulitis.**

tablish a diagnosis of diverticulitis include demonstration of a micro or macroperforation of a diverticulum with the subsequent gamut of roentgen manifestations resulting from this perforation.

Plain film of the abdomen and chest should be obtained in all patients suspected of diverticulitis. While the roentgenographic manifestations are non-specific, the plain films may occasionally demonstrate pneumoperitoneum, air in the urinary bladder, or a soft tissue mass containing mottled air densities that separate the small bowel loops from the sigmoid colon or urinary shadows suggesting an abscess. Reflex ileus is not uncommon but is a non-specific finding. Complete bowel obstruction is rare in diverticulitis.

Barium Studies

The barium enema examination is the study of choice in establishing diagnosis of diverticulitis and can safely be performed on any stable patient in whom free intraperitoneal air has been fairly



Figure 3
Cul-de-sac abscess **causing a mass, cushion defect of the sigmoid colon with speculated folds (arrows) on the barium enema examination of an 82 year-old woman. Contrast media in the urinary bladder is from an urogram.**



Figure 4
Perforation. Abscess cavity (large arrows) in direct communication with sigmoid lumen (small arrow) demonstrated on the post evacuation film from a barium enema in a 62 year-old woman with diverticulitis.



Figure 5
Fistula (arrows) between the sigmoid colon and the small bowel shown on barium enema in a 75 year-old woman with diverticulitis.

well excluded. Whenever frank perforation originating from the colon is known to exist or seriously suspected, iodinated water soluble contrast agents should be used instead of barium to identify the offending diverticulum. (The latter preparation has a tendency to form peritoneal granulomas.) If considerable pain or spasm is encountered during the filling of the colon, intravenous spasmolytics, such as glucagon, should be administered.

Sinus Tracts

A sinus tract signified by the extraluminal collection of barium is the most reliable indicator of diverticulitis. It may be seen as a fleck or streak of barium outside the expected contour of the lumen and may simulate a calcified lymph node or even an artifact. The extravasation may be noted only on the post evacuation film (Figure 1).

Longitudinal pericolonic sinus tracts that parallel the bowel lumen causing "double tracking" appearance, are characteristic for diverticulitis.[4,5] These tracts arise from a focal mucosal perforation of the extraluminal portion of the diverticulum with dissection longitudinally along the bowel axis either in the submucosa or subserosa. These tracts may extend into other diverticuli producing communication with the bowel lumen at multiple sites. Such double tracking however, can be also seen in Crohn's disease of the sigmoid, or in adenocarcinoma.

Cushion Defect

The local pericolic abscess that typically surrounds a perforated diverticulum produces the most frequently observed radiographic sign of diverticulitis—a small filling defect indenting the lumen of the colon. The abscess usually creates an intramural "cushion" defect with a wide base and no tumor nodulation (Figure 2). The overlying mucosal folds are intact, but occasionally edematous, crowded, or distorted, leading to a spiculated appearance that converges towards the abscess (Figure 3).

Abscess

When the abscesses are large they will distort the colon in a fashion characteristic of extrinsic

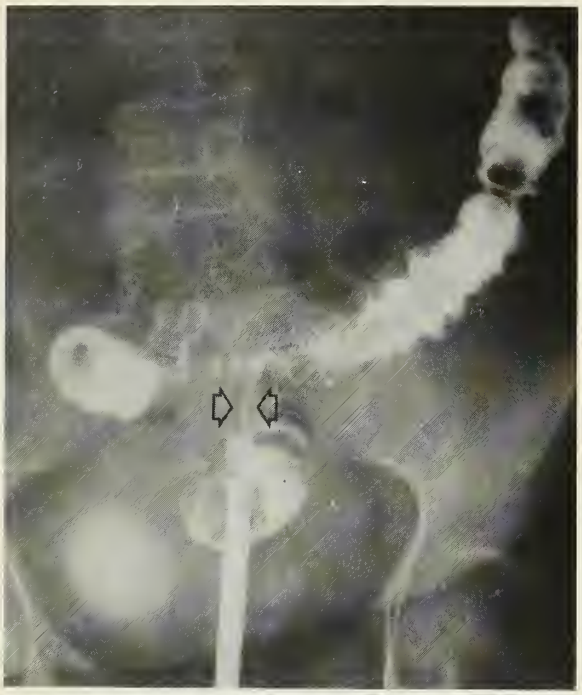


Figure 6
Colovesical fistula in a 55 year-old woman with pneumoturia and fecaluria. The cystoscopy probe (arrows) is passing from the bladder to the colon and contrast, instilled through the scope is seen outlining the sigmoid.

masses (Figure 4). Ultrasonography and nuclear medicine gallium studies are also useful in their evaluation. When small, they are often subtle and spasmolytics may be necessary to differentiate these defects from muscular dysfunction. Adjacent diverticulum may be seen with variable distortion, obliteration, or edema of the properitoneal fat.

Fistulas

The abscesses may extend in any direction in the pelvis causing mass defects, adhesions, or actual fistula between the colon and the neighboring organs such as a loop of small bowel, (Figure 5) a colovesical fistula, (Figure 6) colovaginal fistula, (Figure 7) or a fistula which may extend into the soft tissue of neighboring organs (Figure 8).[6]

Differential Diagnosis

The most important entity to be differentiated from diverticulitis is carcinoma, since both are common in the same age group and often coexist.

Carcinoma typically presents as a completely rigid, fixed lesion with abrupt, shelf-like ends and



Figure 7
Colovaginal fistula and pelvic abscess demonstrated on this lateral rectum spot film from the barium enema in a 49 year-old woman. The abscess is narrowing the rectosigmoid lumen and the fistula (small arrows) is reaching the vagina (large arrows).

loss of the usual mucosal pattern. Ulcerations and nodularity of the mucosa are often found as well. Segments of bowel involved by diverticulitis, by contrast, show tapered margins and contractility. Although severe spasm induced by the diverticulitis may simulate rigidity, the routine use of spasmolytics, *i.e.,* glucagon, should obviate this diagnostic problem. A length of bowel involvement six centimeters or more favors the diagnosis, while significant, associated bleeding and weight loss favor carcinoma. Even with these features in mind, differentiation may be difficult when circumferential narrowing is encountered. In such cases, re-examination of the area in several weeks, following medical therapy, either by colonoscopy or air contrast techniques, should be undertaken to detect mucosal changes and search for coexisting or synchronous carcinoma.

Granulomatous colitis may co-exist and in fact complicate diverticulitis as an apthous ulcer in a diverticulum perforates and results in peridiverticulitis.[7] The hallmark of Crohns disease is edematous, ulcerated mucosa; however, both diseases also share such common findings as fistulae and abscesses.

Metastatic disease as well as endometriosis may produce asymmetrical bowel wall defects simulating a small abscess without the association of diverticular disease.[3] Metastatic carcinoma may even distort the bowel lumen while preserving the mucosal pattern, closely mimicking diverticular disease. In these instances there is usu-



Figure 8
Sinus tract **(arrows) extending from the sigmoid colon down the left leg in a 53 year-old man with diverticulitis. A diverting colostomy was performed.**

ally a great deal of fixation, rigidity, and flattening as well as shortening due to desmoplasia, which usually assist diagnosis.

Ischemic colitis and diverticulitis are both seen in the older age groups and have several common isolated features: mural defects, extravasation of barium and spasm.[8] Ischemic colitis generally affects the watershed area between the inferior mesenteric and superior mesenteric artery supplies at the splenic flexure. The rapid progression of roentgenographic signs in ischemic colitis is not found in diverticulitis.

In summary, when diverticulitis is clinically manifested by its extracolonic complications, the diagnosis is often overlooked. When pelvic masses, bladder or vaginal symptoms are noted, a barium enema should be included in the patient's evaluation to exclude the possibility of diverticulitis. The roentgenographic manifestations include: sinus tracts, extrinsic cushion, mural based mass indenting defects, abscesses and fistula to different organs and soft tissue structures. ◀

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ISMS Convention Summary 1981



ISMS President Fred Z. White, M.D., addresses the House of Delegates.



Shown at head table during President's Night, a dinner/dance to honor Herschel Browns, M.D., are (L-R) Dr. and Mrs. Cyril C. Wiggishoff, Dr. and Mrs. Herschel Browns and Dr. and Mrs. Robert P. Johnson.

Illinois State Medical Society

1981-82 Officers and

Board of Trustees

Officers

PRESIDENT	Fred Z. White, M.D., 723 No. 2nd Street, Chillicothe 61523
PRESIDENT-ELECT	Cyril C. Wiggishoff, M.D., 25 E. Washington, Chicago 60602
1st VICE-PRESIDENT	Robert Johnson, M.D., 108 Maple Grove, Springfield 62707
2nd VICE-PRESIDENT	Maynard Shapiro, M.D., 7531 Stony Island, Chicago 60649
SEC.-TREAS.	Eugene P. Johnson, M.D., P.O. Box 68, Casey 62420
CHAIRMAN, B of T	Morris T. Friedell, M.D., 7531 Stony Island, Chicago 60649

House of Delegates

SPEAKER	Clifton Reeder, M.D., 516 Sheridan Road, Wilmette 60091
VICE-SPEAKER	Julian Buser, M.D., 6600 W. Main, Belleville 62223

Trustees

1st District	1984	John Ring, M.D., 511 E. Hawley, Mundelein 60060
2nd District	1983	Allan L. Goslin, M.D., 712 N. Bloomington, Streator 61364
3rd District	1982	Alfred Clementi, M.D., 675 W. Central Rd., Arlington Hts. 60005
	1983	Audley F. Connor, Jr., M.D., 7531 Stony Island, Chicago 60649
	1982	Jere Freidheim, M.D., 3050 S. Wallace, Chicago 60616
	1984	Morris T. Friedell, M.D., 7531 Stony Island, Chicago 60649
	1983	Robert C. Hamilton, M.D., 25 E. Washington, Chicago 60602
	1984	Henrietta Herbolsheimer, M.D., 1700 E. 56th St., Chicago 60637
	1984	Lawrence L. Hirsch, M.D., 2434 Grace, Chicago 60618
	1983	Harold J. Lasky, M.D., 55 E. Washington, Chicago 60602
	1983	Richard Rovner, M.D., 645 N. Michigan, Suite 920, Chicago 60611
	1983	Joseph Sherrick, M.D., 303 E. Superior, Chicago 60611
4th District	1982	George Burke, M.D., Rock Island Franciscan Hospital, 2701-17th St., Rock Island 61201
5th District	1982	Robert Prentice, M.D., 2248 Warson Road, Springfield 62704
6th District	1984	Robert R. Hartman, M.D., 1040 College, Jacksonville 62650
7th District	1982	Alfred J. Kiessel, M.D., 1 Powers Lane Place, Decatur 62522
8th District	1982	James Laidlaw, M.D., 104 W. Clark, Champaign 61820
9th District	1984	Warren D. Tuttle, M.D., 203 N. Vine, Harrisburg 62946
10th District	1984	Thomas P. Meirink, M.D., 8601 W. Main St., Belleville 62223
11th District	1983	Kenneth A. Hurst, M.D., 52 Bunting Lane, Naperville 60540
12th District	1983	Joseph Perez, M.D., 5670 E. State, Rockford 61108
Trustee-at-Large	1982	Herschel Browns, M.D., 4600 N. Ravenswood, Chicago 60640

Highlights of the 1981 Annual Meeting

ISMS House of Delegates

The 141st Annual Meeting of the Illinois State Medical Society convened April 5-7, 1981, at the Radisson Chicago Hotel. More than 600 physicians, auxilians, medical students, medical residents and guests attended.

The first session of the House of Delegates was called to order by Robert P. Johnson, M.D., speaker, at 10:00 a.m., Sunday, April 5, 1981.

In pursuit of a tradition initiated at the 1980 Annual Meeting, ISMS past presidents were invited to lead the House in an opening invocation for each session. On Sunday, the invocation was given by J. M. Ingalls, M.D., 1975-76 president. Fredric D. Lake, M.D., 1974-75 president, gave Monday's invocation, and on Tuesday the honor was extended to Joseph H. Skom, M.D., 1976-77 president.

ISMS Secretary-Treasurer, Eugene P. Johnson, M.D., conducted a brief memorial for those members who had died in the past year.

Report of the Chairman, ISMS Board of Trustees

Morris T. Friedell, M.D., chairman, ISMS Board of Trustees, presented an update on activity since the 1980 Interim Meeting, indicating that all items referred by the House of Delegates had been addressed.

Dr. Friedell related that the Board of Trustees had approved 1981-82 goals for ISMS, which had been developed by the ISMS Committee on Planning and Priorities. The Board had authorized distribution of the goals to the House for information. (The 1981-82 goals are further elucidated in the enclosed Abstracts of Actions, ISMS Board of Trustees.)

Reference Committees Convene

Reference Committees met at 1:30 p.m. Sunday afternoon. Open hearings were conducted on 44 resolutions, as well as reports from ISMS councils and committees, affiliate groups and Illinois governmental agencies.

At the conclusion of open hearings, each reference committee met in executive session to evaluate information and recommend formal action by the House of Delegates.

Past Presidents' Dinner

On Saturday evening, April 4, seventeen ISMS past presidents and retiring ISMS Executive Administrator Roger N. White gathered for the eighteenth annual Past Presidents' gourmet dinner at the Chicago Park Hyatt Hotel. David S. Fox, M.D., 1978-79 ISMS president, served as master of ceremonies, honoring immediate past president P. John Seward, M.D., and Mr. White.

ISMS Fifty Year Club Luncheon

A total of 97 physicians were inducted as members of the ISMS Fifty Year Club at a Monday afternoon luncheon. The Fifty Year Club now boasts some 915 members who graduated from medical school at least 50 years ago. Lawrence L. Hirsch, M.D., served as master of ceremonies. These included a talk by Dr. Philip Thorek, a new Fifty Year Club member, who presented an eclectic series of satirical observations on medical practice and its social milieu.

One physician received his sixty-year pin in a personal presentation by Dr. Hirsch. Dr. Carl F. Steinhoff, who had supervised Dr. Hirsch during his medical internship, received that honor.

RPS: Loss Prevention Education

The ISMS Resident Physician Section sponsored a program in loss prevention on Saturday morning, April 4. Coordinated by the ISMS Committee on Loss Prevention Education, this presentation was part of an ongoing ISMS/ISMIS effort to foster physician ability to identify liability



ISMS Past Presidents' Dinner (Standing, L-R): Harlan English, M.D., J. Ernest Breed, M.D., Newton DuPuy, M.D., George T. Wilkins, Jr., M.D., Jacob E. Reisch, M.D., Willard C. Scrivner, M.D., J.M. Ingalls, M.D., Frank J. Jirka, M.D., C.J. Jannings, M.D. and Joseph H. Skom, M.D. Seated (L-R) are Leo P.A. Sweeney, M.D., Mr. Roger N. White, David S. Fox, M.D., P. John Seward, M.D. and H. Close Hesseltine, M.D.

areas, procedures to improve patient care and reduce legal vulnerability.

Medicine: 1990

The ISMS Medical Student Section sponsored a Saturday afternoon program on future medical practice. Speakers included Michael Prerodor, M.D., who presented an update on hospice medicine; Rosemary Rau-Levine, M.D., an expert in holistic medicine, and Allan H. Levy, M.D., whose talk was entitled "Computers at the Bedside: Boon or Bane?"

The annual business meeting of the Medical Student Section (formerly entitled the Student Business Section) included election of officers for 1981-82: Michael Nieder, chairman; Kurt Elward, vice chairman; Linda Tetzlaff, secretary/editor; Ron Davis, delegate and Malcolm Major, alternate delegate.

Substance Abuse: Clinical Aspects

The ISMS Committee on Alcoholism and Drug Dependence sponsored this seminar with the support of a grant from the Division of Alcoholism, IDMHDD. Presentations included dramatization of a family therapy session, coordinated by Linda Kyle-Spore, alcoholism counselor and coordinator, family therapy program, Northwestern Memorial Hospital Institute for Psychiatry. "Women and Alcohol" was the topic of a talk by Edith S. Gomberg, Ph.D., University of Michigan School of Social Work.

James W. West, M.D., chairman of the ISMS Panel for the Impaired Physician, discussed the Panel's activities. He presented unique aspects of physician impairment and means to assist troubled colleagues.

Edward C. Senay, M.D., committee chairman, discussed recent trends in drug abuse, and recommended avenues for triage of specific drug reactions. Lee Gladstone, M.D., director, Alcoholism Treatment Program, Northwestern Memorial Hospital, presented a laboratory matrix approach to diagnosis of the alcoholic patient. Finally, a representative of Alcoholics Anonymous summarized the AA approach to alcoholism, urging the integration of AA in long-term therapy plans.

Public Affairs Breakfast

The Honorable George H. Ryan, (R-43)



(L-R) The Hon. George H. Ryan (R-43), speaker, Ill. House of Representatives, Rep. Jane Barnes (R-Oak Lawn) and ISMS Executive Administrator Roger N. White, at the Public Affairs Breakfast.



Members of the ISMS Fifty Year Club.

Speaker of the Illinois House of Representatives, gave the keynote presentation at the ISMS Public Affairs Breakfast on Monday morning, April 6. Sponsored by the ISMS Public Affairs Committee and chaired by Don Hinderliter, M.D., the breakfast was attended by more than 300 persons. Speaker Ryan was introduced by Representative Jane Barnes (R-Oak Lawn), chairman of the House Health and Family Services Committee, who described activities of House committees responsible for health legislation.

Representative Ryan, a practicing pharmacist, urged physician involvement in the political process. He discussed several pending legislative proposals, including those to permit optometrists to prescribe drugs, dissolution of the Illinois Health Finance Authority and repeal of drug substitution laws. Noting that members of the Illinois legislature include pharmacists, chiropractors, dentists, and optometrists, but no physicians, he urged that doctors make an effort to communicate with their legislators in health-related matters.

Leadership Conference

More than 200 persons attended the ISMS Leadership Conference on Monday morning, April 6, and participated in a lively exchange of perspectives and ideas. Walter McClure, Ph.D., senior vice-president of policy analysis for Interstudy, a Minneapolis administrative consulting firm, discussed "The Choice Before Us—Regulation or Competition." Emphasizing that medical practice would continue to evolve in either a regulatory or competitive political milieu, he urged personal involvement in policymaking. Gary Appel, Ph.D., president of the Council of Community Hospitals, Minneapolis, discussed competition within various delivery systems. Martin Koldyke, chairman, and Michael Koetting, acting director, Illinois Health Finance Authority, explored the Illinois Rate Review Law. Dave Vogel, president of a management consulting firm from Albuquerque, New Mexico, examined Individual Practice Associations, while John J. Ring, M.D., vice chairman of the AMA Council on Medical Service, presented the AMA position on alternative delivery systems. A panel of responders led discussion of the items presented.

Auxiliary Reflections

Mrs. Harlan Failor, ISMS Auxiliary president, reported to the House of Delegates on Monday, April 6. This year's successes had included membership increases in nearly every county auxiliary, and implementation of a new membership program for student and resident physician spouses. ISMSA had received first place national awards for their support of the American Medical Association Education and Research Foundation, as the state with the largest auxiliary contribution, largest combined physician/auxiliary contribution and largest per capita contribution in the North Central Region.

Mrs. Failor discussed extensive efforts in health education and immunization awareness,



ISMS Auxiliary President Mrs. Harlan Failor accepts gift from Arthur R. Traugott, M.D., delegate, representing the physicians of Champaign County.



Theodore R. Sherrod, M.D., Ph.D., (L) receives Edwin S. Hamilton Teaching Award from Fred Z. White, M.D., ISMS president-elect.

stressing the support of ISMS in each instance. Scholarships for health education and benevolence had continued to receive attention. "While our spouses are in their offices healing illness, we have been in our communities teaching wellness," she said. "We have come that proverbial 'long way' from May, 1922, when the Auxiliary was organized to 'assist in entertainment at all medical conventions'."

Illinois Society, American Association Of Medical Assistants

Elaine Kaiser, CMA-A, president, Illinois Society, American Association of Medical Assistants, was introduced to the House by John Wright, M.D., chairman, AAMA Advisory Board. Mrs. Kaiser stressed appreciation for ISMS support of AAMA projects, and entered a plea for support of medical assistants by practicing physicians.

Accreditation Surveyors Honored

Morris T. Friedell, M.D., chairman, ISMS Board of Trustees, was assisted by Vice Speaker Clifton L. Reeder, M.D., in presenting plaques to the physicians, osteopaths and Ph.D.'s who had served as CME accreditation site visit examiners in the past year. So honored this year were: Morgan Meyer, M.D., Eugene Johnson, M.D., Robert Steptoe, M.D., Ross Hutchison, M.D., Henri Havdala, M.D., Thomas Zimmerman, Ph.D., Robert Fox, M.D., David Roxe, M.D., Bradford W. Claxton, M.Ed., Joseph B. Perez, M.D., Thomas O. Henderson, Ph.D., Frank J. Jirka, M.D., Joseph R. O'Donnell, M.D., Charles Weigel, M.D., Joseph Daddino, M.D., L. W. Tanner, M.D., Sheldon S. Waldstein, M.D., Eugene Scherba, M.D., John Holland, M.D., Linda Gunzburger, Ph.D., Donald Pochyly, M.D., M.Ed., William Lees, M.D. (posthumous), Roger Wujek, M.D., Harold Paul, M.D., M.Ph., Ernest Bone, M.A., M.D., Chase Kimball, M.D., Ben Blivaiss, Ph.D., Alfred Clementi, M.D., Marten Kernis, Ph.D., John G. Demakis, M.D., Kenneth Hurst, M.D., Ward Perrin, D.O., Joseph Sherrick, M.D., Michael Dykes, M.D., M.Ed., Fred Z. White, M.A., M.D., Anthony Barbato, M.D., and Charles Osborne, Ed.D.

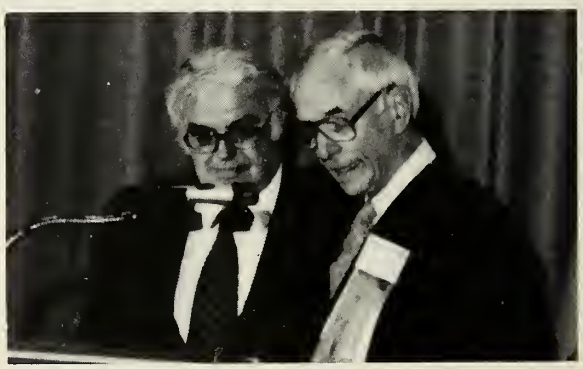
Edwin S. Hamilton Teaching Award

Theodore R. Sherrod, M.D., Ph.D., a professor of pharmacology at the University of Illinois College of Medicine, received the Edwin S. Hamilton Teaching Award during Monday's House of Delegates Session. Fred Z. White, M.D., ISMS president-elect, a member of the Interstate Postgraduate Medical Association of North America, presented the award to Dr. Sherrod.

An educator and practicing physician, Dr. Sherrod was cited for his career in research, training and public service. Students had voted him recipient of the "golden apple award" for teaching, as well as 1976 UI faculty member of the year.

AMA-ERF Check Presented

Herschel Browns, M.D., ISMS president, introduced Robert B. Uretz, M.D., dean, University of Chicago Pritzker School of Medicine, acting as representative of the Illinois Council of Medical School Deans. Dr. Browns presented a check to Dr. Uretz in the amount of $187,137, representing this year's contribution to Illinois medical schools from the American Medical Association Education and Research Foundation.



Robert B. Uretz, M.D., (L) accepts AMA-ERF check from ISMS President Herschel Browns, M.D.

IMPAC Reports



Paul Mahon, M.D., IMPAC chairman, reported that 1980-81 had been a busy year for that group. Much effort had been given to assisting candidates in campaign management, design of political tabloids and advertising promotion.

Membership of 5,652 was reported for 1980, including 225 interns and residents, 224 emeritus members and 86 non-physicians. While the total membership for 1980 is 13 less than in 1979, Dr. Mahon reported, it represented 44% of ISMS members, "a far better percentage than most other state and corporate PACs."

Dr. Mahon reported that IMPAC had been involved in 216 state and federal campaigns during the November general election. Of candidates supported for posts in the Illinois Senate, 89% had been successful. 95% of candidates supported for the Illinois House had been elected, as had 78% of those supported for the U.S. House and Senate.

Dr. Mahon lauded the high membership participation, and urged that more physicians join IMPAC and increase their involvement in government.

ILLINOIS STATE MEDICAL SOCIETY

presents this

Certificate of Commendation

to

ROGER N. WHITE

In recognition of 21 years of dedicated service, including a 12-year tenure as Executive Administrator. ISMS has been both proud and fortunate to have as its chief administrative officer an individual firmly committed to serving the best interests of the Society.

Leadership coupled with integrity gained for you the respect of the Society's officers, trustees and members.

While the passage of time may dim the memory of events, it will not diminish the gratitude of this Society for your efforts. May the future fulfill our sincere best wishes for good health, happiness and prosperity.

Presented April 5, 1981

Report Of The Executive Administrator

Roger N. White, ISMS executive administrator, addressed the House on Monday afternoon. As Mr. White would soon retire, this was his final address to the House. Rather than limit his comments to events of the past year, he gave an overview of his 21 years with ISMS.

Recounting his introduction to the House of Delegates in 1960 was director of medical services and economic research on the newly reorganized ISMS staff, Mr. White recalled that his association with the Society was concomitant with a decision to modernize and move the headquarters from Monmouth to Chicago. "The dues were doubled from $40 to $80," he recalled, "and ISMS was off and running as a leading medical society."

Mr. White was responsible for formation of the Illinois State Medical Society Inter-Insurance Exchange, and initiation of effective communication with state regulatory agencies and the news media. His tenure witnessed volatile changes in medical practice and the social environment, and he oversaw relationships with the first foundations for medical care, professional standards review organizations, health maintenance organizations, individual practice associations and a host of other developments. His stewardship guided ISMS through the malpractice crisis, the threat of national health insurance and the advent of the National Health Planning Resources Development Act.

In closing his comments, Mr. White expressed appreciation to his staff and best wishes for ISMS. "As I move off the stage and the transition begins," he said, "I can't help but reflect on the many relationships I have enjoyed during my tenure with this society—with members of the House, members of the Board and with other leaders. I'm grateful and I thank you for these opportunities—it has been rewarding and uplifting."

At the conclusion of Mr. White's talk, Morris T. Friedell, M.D., chairman, ISMS Board of Trustees, presented him a plaque in appreciation of his contribution to ISMS. "No one appreciates more the quality of leadership than the officers of this organization," Dr. Friedell said. "No one has built a better staff than Roger N. White. The last decade of this Society's life has been proven its most exciting, trying and difficult." He then read to the House the text of Mr. White's plaque

(see box). The presentation closed with a standing ovation.

President's Valedictory

ISMS President Herschel Browns, M.D. gave his closing comments to the House on Monday afternoon. Dr. Browns' talk traced trends of the recent past and responsibility for the future.



Retiring President Herschel Browns, M.D., (L) accepts commemorative clock from Morris T. Friedell, M.D., chairman, ISMS Board of Trustees.

The President's Tour had been rewarding, he told the House, and personal visits to county societies had brought him to believe that physician distribution was beginning to come into balance, that county society members were well informed and that business and industry showed increasing interest in health care issues. Membership, Dr. Browns told the House, remained an area of vital concern. Reflecting on the increase in specialty societies within organized medicine, he said, "A case can be made for special attention by various groups to special needs. But the undeniable result is fragmentation and that must be weighed against medicine's need for a strong, single voice."

Noting that his inaugural address had targeted possible "rationing of health care" as the major challenge for the decade, Dr. Browns brought attention to present plans for block grants, budget cuts and cost caps. "The so-called competition bills in Congress are the stepchildren of the cost containment programs of the last decade," he told the House. "But the spectre of insufficient funds to meet health care needs is a new reality. We must make the system more efficient. We must conserve the health care dollar if we expect to retain the necessary programs."

Dr. Browns called for patient education regarding preventive medicine and avoidance of stressful behaviors in containing health care costs.

Illinois Delegation To The AMA

The Illinois Delegation to the American Medical Association was introduced to the House of Delegates and lauded for its labors in the previous year. Its written report detailed proposals brought before the AMA House regarding sale and use of AFP (alpha-fetoprotein) diagnostic kits and direct membership provisions. Illinois delegates had elected a new chairman, Theodore Grevas, M.D., and secretary, Howard C. Burkhead, M.D., after the AMA Interim Meeting in December.

Service Plaques Awarded

Physicians who received plaques in recognition of their service to ISMS in an official capacity were Robert P. Johnson, M.D., retiring speaker; Lawrence L. Hirsch, M.D., retiring 1st vice pres.; George T. Mitchell, M.D., retiring 2nd vice pres.; and Julian W. Buser, M.D., retiring trustee from the 10th district.

At the Monday afternoon session of the House of Delegates, Executive Administrator Roger N. White presented a plaque in recognition of twenty years' service to Allan F. Ford, ISMS in-house printer. On Wednesday morning, a fifteen year service plaque was awarded before the Board of Trustees to Elizabeth E. Duffy, assistant director, division of education, manpower and convention services.

President's Night

Monday evening, April 6, 230 persons at-



Members of the ISMS Delegation to the American Medical Association

tended the annual dinner dance honoring Herschel Browns, M.D., ISMS president. Cyril C. Wiggishoff, M.D., served as master of ceremonies for the program, which featured music by the Dick Judson orchestra.

One highlight of the evening was presentation of a gold watch to ISMS Executive Administrator Roger N. White, in honor of his services to ISMS. ISMS President Dr. Browns and Chairman, Board of Trustees, Dr. Morris Friedell, presented the watch.

Fred Z. White, M.D. Inducted As 129th ISMS President

At the final session of the House on Tuesday, April 7, Herschel Browns, M.D. administered the oath of office to Fred Z. White, M.D., as 1981-82 president of the Illinois State Medical Society.

In his inaugural address, Dr. White stressed the importance of participation and flexibility in a changing social environment. "In a society as alive and dynamic as ours," he told the House, "change is the only constant. In recent years, there have been threats to the practice of medicine, challenges to our profession and changes in the political and economic climate. We again face this triad of change, threat and challenge."

Noting a current political emphasis on competition over regulation, he advised of "new acronyms to learn and systems to understand." Dr. White called for intelligent participation in any new governmental approaches. "We must look at the societal and economic data in the same non-emotional manner that we examine our scientific data," he said. "We must test the new approaches suggested by society in the same cautious and calculated manner we employ to check a new procedure or therapeutic regimen."

Stressing the importance of participation in society's decision making processes, Dr. White called for responsible peer review mechanisms. "A profession must have autonomy and control over its members and their activities," he said. "Only physicians have the level of competence and skill to capably judge other physicians. We must be concerned with the purity of our profession. To protect those who put self-interest above service to the public and patients is to demean our profession."

Availability of financial aid to needy medical students and somewhat disparate interests of medical specialty groups were among issues to address in the coming year, Dr. White told the House. "Specialty societies, hospitals, medical schools and economic groupings all clamor to speak for their special and specific interests," he said. "The outcome of that process, if carried to its ultimate conclusion, can only be confusion and noise, not a clear voice. In Illinois this clear voice can, and should, come from ISMS."



Retiring ISMS President Herschel Browns, M.D., (L) accepts Past President's Medallion and plaque from ISMS President Fred Z. White, M.D.

In closing, Dr. White called for a perspective on the "greater good," and concentration on common goals over minor differences. "The extension of this greater good to society is also important, and we must keep in mind that what is best for our society as a whole will be best for us as a profession, as a medical society and as individuals. For this greater good, and for our society, it will be my pleasure to work with you in the coming year."

Past President's Medallion

Newly installed president Fred Z. White, M.D., presented the Past President's Medallion to Herschel Browns, M.D., with notes of appreciation for his work as ISMS president in the past year, citing Dr. Browns as a "tremendous role model." Robert P. Johnson, M.D., speaker of the House of Delegates, presented a scrapbook of news clippings recounting Dr. Browns' activities, compiled by the Council on Public Relations.

Final Business And Elections

The final business, including election of officers and trustees, as well as members of the ISMS Judicial Panel, was completed on Tuesday, April 7. These items are detailed in the "Summary of Minutes, Annual Meeting, House of Delegates."

SUMMARY OF MINUTES

1981 Annual Meeting

House of Delegates

The ISMS House of Delegates met at the Radisson Hotel in Chicago, April 5-7, 1981, and took the following actions. The official minutes of the House are on file at the Illinois State Medical Society office.

Due to the complexity of amendments to policy manual statements, only the approved, revised policy statements are reflected in this text. Persons wishing to study the nature of approved changes may refer to the October 1980, reference issue, where the former policy statements are published.

OLD BUSINESS

80I-16—Adopted
(BOT Rep. B)—Revision of Policy Manual Statement on "Hospital Records and Their Availability."
Introduced by Fred Z. White, M.D., for the Board of Trustees

Amended and Retitled Policy Manual Statement to read:

PATIENT CARE RECORDS AND THEIR AVAILABILITY

Patient Care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in cases of psychiatric illness. In the case of non-hospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs to accomplish scientific studies of morbidity or mortality, utilization review, peer review or other patient care, improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees.

Pursuant to a subpoena for records, a physi-

cian is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, *Illinois Revised Statutes,* Chapter 48, Section 138.8; Chapt. 51, Section 71, 73 and 101; Chapt. 91½, Sec. 800ff.

80I-22—Not Adopted
(BOT Rep. C)—Presumption of Liability of a Provider Under PSRO Review
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Defeated this resolution which called upon ISMS to enjoin Health Care Financing Administration, through legislation and negotiation, "from authorizing intermediaries to deny payment to a physician who is only under investigation for questionable practice patterns under PSRO review."

80I-27—Not Adopted
(BOT Rep. D)—State Motorcycle Helmet Law
Introduced by Ronald M. Davis for the ISMS Student Business Section

Defeated this resolution which called upon ISMS to "support the enactment and preservation of a state law in Illinois requiring the use of a full-face helmet when riding a motorcycle."

Sub. 80I-29—Referred to Ref. Com. C
(BOT Rep. E)—Mandatory Learning Contracts
Introduced by Ronald M. Davis for the ISMS Student Business Section

80I-13, 80A-52—Referred to Ref. Com. C
(BOT Rep. F)—Medical Research Involving Human Experimentation and Amendment of Policy Manual Statement on "Experimental Medical Procedures"
Introduced by Gilbert Bogen, M.D. and Morris T. Friedell, M.D., for the Board of Trustees and the Medical-Legal Council

REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

9(A-81)—Adopted
Deletion of Policy Manual Statement on "Constitution & Bylaws"
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Deleted "Constitution & Bylaws" statement from the Policy Manual because this subject is adequately covered in Bylaws Chapter IX, Section 7.

13(A-81)—Not Adopted
Single Meeting of House of Delegates
Introduced by Kenneth E. Ambrose, M.D., for the Warren County Medical Society

Defeated this resolution which called upon ISMS to "return to the former practice of holding a single regular annual meeting of the House of Delegates and such special, or called, meetings as shall be deemed necessary by the officers and trustees of this society."

21(A-81)—Adopted
Amendment to Chapter IV, House of Delegates, Section 4, Time and Place of Meetings
Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter IV, Section 4, by adding:

"Within 100 days after the annual meeting, the Board of Trustees shall decide if there is to be an interim meeting. If the Board finds that there is not sufficient, relevant business for the House, the Board may cancel the interim session."

14(A-81)—Not Adopted
Membership with AMA
Introduced by Richard Rudman, M.D., for the Marion County Medical Society

Defeated this resolution which called upon ISMS to amend Bylaws Chapter II, Section 1 "to make membership in AMA optional rather than compulsory for members and potential members of ISMS."

19(A-81)—Adopted
Change of Name for ISMS/SBS
Introduced by Ronald M. Davis, for the ISMS Student Business Section

Changed the name of the Student Business Section of ISMS to the Medical Student Section of ISMS and directed that appropriate changes be made in the ISMS Bylaws.

22(A-81)—Adopted as Editorially Amended
Amendment to Part 7, Chapter XI—Ethical Relations—to Clarify Procedure for Filling Vacancies on Judicial Panel
Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter XI as follows:

PART 7. JUDICIAL PANEL (4th Paragraph)

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such an interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws.

23(A-81)—Adopted
Amendment to Chapter IV. House of Delegates
Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter IV, Section 11 to provide that "Resolutions to be mailed to the (ISMS House of) delegates prior to the annual or interim meeting must be received at ISMS headquarters thirty days prior to the annual or interim meeting."

24(A-81)—Adopted as Amended
Amendments to Chapters I, X and XI to Conform with ISMS Policy on Autonomy of County Medical Societies
Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws to conform with ISMS policy on "Autonomy of County Medical Societies" by deleting requirements that ISMS members must comply with the provisions of the AMA Constitution and Bylaws and the AMA Principles of Medical Ethics.

38(A-81)—Adopted as Editorially Amended
Amendments to Chapter XII, Part 2, Section D, Appeals and Chapter XII, Part 4, Section A, ISMS Procedures
Introduced by Lawrence L. Hirsch, M.D., for the Board of Trustees

Amended Bylaws Chapter XII to clarify the role of the ISMS Peer Review Appeals Committee as a body which merely reviews local proceedings to insure physicians have received due process, rather than rehearing the facts of a case.

REFERENCE COMMITTEE A

28(A-81)—Adopted
Uniform Student Membership Application
Introduced by Ronald M. Davis for the ISMS Student Business Section

Requested county medical societies to "work together with ISMS/SBS to develop a concise and uniform medical student application for membership form."

Substitute 31(A-81)—Adopted
Weekend Meetings of ISMS Committees
Introduced by Ernest F. Adams, M.D. for the Peoria Medical Society

Instructed the Board of Trustees to "encourage membership involvement in Council and Committee activities by permitting evening and weekend meetings at convenient locations at the discretion of the chairman of the Council or Committee in consultation with the Council or Committee members."

Filed the following reports for information: President, President-Elect, 1st Vice President, 2nd Vice President, Chairman of the Board of Trustees, Trustees, Trustee At Large, Executive Administrator, Secretary-Treasurer, AMA Delegation, ISMS Auxiliary, Illinois Society of American Association of Medical Assistants, Illinois State Medical Insurance Services, Inc.

REFERENCE COMMITTEE B

11(A-81)—Referred to Board for Study
Freedom of Choice Health Insurance Legislation
Introduced by Robert R. Hartman, M.D. for the Board of Trustees

Referred to the Board of Trustees for study a proposal to seek amendments to existing insurance laws which would "Provide consumers and those offering health insurance the opportunity to mutually determine the benefits covered (including physicians' services) in the health insurance offered and purchased."

16(A-81)—Referred to Board for Study
Stopping Expansion of Health Maintenance Organizations & Individual Practice Associations
Introduced by Samuel J. Schimel, M.D.

Referred to the Board of Trustees for study a proposal that ISMS "make every effort to stop the expansion of Health Maintenance Organizations and Individual Practice Associations in the State of Illinois by directing the Board of Trustees to take specific action to counteract the propaganda of HMO's and IPA's."

Substitute 18(A-81)—Adopted in Lieu of 18(A-81) & 25(A-81)
Stopping Expansion of PSRO's
Introduced by Samuel J. Schimel, M.D.
PSRO, The Abolition of
Introduced by Walter D. Stevenson, III, M.D. for Adams County Medical Society

Instructed ISMS to "endorse the AMA House of Delegates' recent action seeking repeal of PSRO Law (P.L. 92-603)."

33(A-81)—Adopted as Amended
Multiple Coverage Options for Health Insurance Plans
Introduced by Ernest F. Adams, M.D., for Peoria Medical Society

Endorsed the principle that "under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible"; and directed the Society to submit this resolution to the AMA House of Delegates for implementation.

44(A-81)—Adopted as Amended
Proposed Reductions of Available Drugs in IDPA Drug Manual
Introduced by Fred Z. White, M.D. for the Board of Trustees

(1) Approved the concept that ISMS recommendations on pharmaceutical products to be included in the IDPA Drug Manual should be based on "therapeutic effectiveness, rather than cost"; (2) Directed the Society to inform IDPA that—while ISMS members will continue to be cost conscious in all areas of medical care—this care must be based on therapeutic considerations and bio-equivalence; and (3) Requested IDPA to consult with ISMS regarding potential problems raised in the Department's cost containment proposal.

Substitute 45(A-81)—Adopted
IHA 1980 Resolution on Commercial Review in Direct Competition with Foundations for Medical Care
Introduced by Walter D. Stevenson, III, M.D., for Adams County Medical Society

Directed ISMS to "communicate to the Illinois Hospital Association and other appropriate parties its strong disapproval of a recently-approved IHA resolution on commercial review"; and instructed the Illinois AMA Delegation to introduce a resolution on commercial review programs in the AMA House of Delegates.

Filed the following reports for information: Committee on Health Planning and Illinois Department of Public Aid

REFERENCE COMMITTEE C

801-29—Not Adopted
(BOT Rep. E)—Mandatory Learning Contracts
Ronald Davis for the ISMS Student Business Section

Defeated this resolution which called upon ISMS to: (1) "Investigate ways to improve residency programs in order to attract and retain more medical graduates in Illinois"; and (2) "Oppose any type of mandatory learning contracts for Illinois medical students and . . . any tuition increase in state-supported schools when such an increase is designed to induce students to sign learning contracts."

Sub. 80A-52—Adopted in Lieu of 80A-52 & 80I-13
(BOT Rep. F)—Medical Research Involving Human Experimentation
Introduced by Gilbert Bogen, M.D.
Amendment of Policy Manual Statement on "Experimental Medical Procedures"
Introduced by Morris T. Friedell, M.D. for Board of Trustees

Amended—by deletion and substitution—ISMS Policy Statement entitled "Experimental Medical Procedures" to read:

EXPERIMENTAL MEDICAL PROCEDURES
With respect to experimental medical procedures, physicians should adhere to and affirm the following:

1. Accepted ethical standards;
2. The Codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;
3. Appropriate Illinois Statutory or regulatory requirements.

1(A-81)—Adopted
Manipulative Casting of Congenital Deformities of the Extremities
Introduced by Michael R. Treister, M.D.

Mandated publication of the following statement in the ISMS Policy Manual: "The Manipulative Casting of Congenital Deformities of the Extremities, whether performed in the office or hospital, is considered by the Illinois State Medical Society to be a surgical procedure"; and directs the Illinois AMA Delegation to present this or a similar resolution for adoption by the American Medical Association.

Substitute 2(A-81)—Adopted
Prevention of Death from Anaphylactic Reactions to Stings by Stinging Insects
Introduced by Donald W. Aaronson, M.D.

Mandated ISMS to "encourage the Illinois Office of Education and the Illinois Department of Public Health to develop mechanisms authorized under Illinois PA 81-1518 to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician."

3(A-81)—Adopted
Deletion of Policy Manual Statement "Publication of Research Data"
Joseph C. Sherrick, M.D. for Board of Trustees

Deleted "Publication of Research Data" statement from Policy Manual because other policies adequately provide for the concerns expressed in this statement.

5(A-81)—Adopted
Continuing and Modifying Policy Manual Statements Entitled "Journal Publication" and "IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings"
Introduced by Joseph C. Sherrick, M.D. for Board of Trustees

Combined and modified Policy Manual Statements entitled "IMJ Publication of Clinical Materials from ISMS-Sponsored Meetings" and "Journal Publications" into a single Policy Manual Statement to read:

ILLINOIS MEDICAL JOURNAL
The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The Committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.

8(A-81)—Adopted
Revision in Policy on Continuing Education
Introduced by Alfred J. Kiessel, M.D. for Board of Trustees

Amended the following policy to read:

CONTINUING EDUCATION

Continuing education is one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multifaceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education. The Illinois State Medical Society should have the primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities which are in conformance with licensing regulations of the State of Illinois. Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

Filed the following reports for information: Council on Education and Manpower, Resident Physicians Section, Student Business Section, Educational and Scientific Foundation, Publications Committee and Illinois Council on Continuing Medical Education

REFERENCE COMMITTEE D

4(A-81)—Adopted
Deletion of Policy Manual Statement on "Health Care—Ancillary Services"
Introduced by Allan L. Goslin, M.D. for Board of Trustees

Deleted the Policy Manual Statement on "Health Care—Ancillary Services," because it was outdated.

6(A-81)—Adopted as Amended
Amendment to the Policy Manual Statement on "Immunization Programs"
Introduced by Alfred J. Kiessel, M.D. for Board of Trustees

Amended this Policy Manual Statement to read:

IMMUNIZATION PROGRAMS

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection, or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws.

In addition, physicians should participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed or supported by the local or state medical society.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary including appropriate state indemnifications or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of the vaccine paid for by public funds.

7(A-81)—Adopted
Amendment to the Policy Manual Statement on "Drugs, Prescriptions"
Introduced by Alfred J. Kiessel, M.D. for Board of Trustees

Amended this ISMS Policy Manual Statement to read:

DRUGS, PRESCRIPTIONS

Prescription drugs should be dispensed only upon the authorization of a physician li-

censed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Generic drug substitution may be considered within legal limits.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.

10(A-81)—Adopted as Amended
Death with Dignity Legislation
Introduced by P. John Seward, M.D. for Board of Trustees

Amended the ISMS Policy Manual Statement on "Death with Dignity" to read:

DEATH WITH DIGNITY
The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based upon what must necessarily be a private matter between physician and patient. If passage of such legislation is imminent, it must provide immunity from civil and criminal penalties for physicians who act in good faith and in accordance with accepted medical practice and must not require physicians to act in violation of their own personal beliefs, morals and conscience.

12(A-81)—Adopted
Definition of a Hospice Program
Introduced by Alfred J. Kiessel, M.D. for Board of Trustees

Defined a hospice program as follows:

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either inpatient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.

30(A-81)—Adopted
Reimbursement for Emergency Care Rendered in the Physician's Office
Introduced by Joseph R. O'Donnell, M.D. for DuPage County Medical Society

Encouraged insurance carriers that offer insurance plans which cover emergency medical services to pay for such services regardless of where they are rendered.

32(A-81)—Not Adopted
Peer Review Activities by County Medical Societies
Introduced by Ernest F. Adams, M.D. for Peoria Medical Society

Defeated this resolution which called upon ISMS legal counsel to "reconsider the earlier opinion discouraging peer review activities by county medical societies to see if they can be resumed."

Substitute 43(A-81)—Adopted
Satellite Emergency Clinics
Introduced by Joseph R. O'Donnell, M.D. for DuPage County Medical Society

Directed ISMS to: (1) Develop a report to the membership for publication in the *Illinois Medical Journal* on hospital satellite emergency rooms in Illinois; and (2) Introduce a similar resolution to the AMA House of Delegates.

Filed for information the following reports: Council on Medical Services, Council on Economics, Council on Mental Health and Addiction, Illinois Department of Public Health, Illinois Department of Mental Health and Developmental Disabilities, Department of Children and Family Services, Illinois Department of Corrections and Department of Rehabilitation Services.

REFERENCE COMMITTEE E

17(A-81)—Adopted as Amended
Delay in New Physician State Licenses
Introduced by Walter D. Stevenson, III, M.D. for Adams County Medical Society

Directed the Society to "propose a means to the Department of Registration and Educa-

tion which will expedite screening and approval of new physician licenses, building upon present statutory provision allowing a physician to practice in cases where applications are complete, screening shows no deficiencies, and issuance of a license would not occur within a reasonable time, so that less than four (4) weeks will elapse between receipt of a complete application and action is taken to notify the applicant of his license status."

Substitute 20(A-81)—Adopted
Rescind Use of the Triplicate Prescription Form in Illinois
Introduced by James Duesman, M.D. for Rock Island County Medical Society

Directed the Board of Trustees to: (1) Review all drugs currently requiring the triplicate form and make recommendations to the Dangerous Drugs Commission on the appropriateness of their inclusion; and (2) Recommend to the Illinois Department of Registration and Education and the Dangerous Drugs Commission a review of the current triplicate prescription program to see what improvements in efficiency can be made in this program.

27(A-81)—Adopted as Amended
Cardiopulmonary Resuscitation
Introduced by Ronald Davis for ISMS Student Business Section

Directed ISMS to "support legislation in the Illinois General Assembly that would encourage basic cardiac life support training in Illinois high schools."

29(A-81)—Referred to Board for Study
Pre-Marital Testing for Syphilis
Introduced by Joseph R. O'Donnell, M.D. for DuPage County Medical Society

Referred to the Board of Trustees for study a proposal that ISMS actively promote the revocation of all mandatory premarital testing for syphilis.

35(A-81)—Not Adopted
Repeal of Public Act 78-282 (Pap Smears)
Introduced by Robert F. Hamilton, M.D. for Madison County Medical Society

Defeated this resolution which called upon ISMS to "advocate repeal of Public Act No. 78-282, and forward this decision to the Illinois General Assembly." It was determined that this resolution was unnecessary because—upon direction of the House last fall—ISMS has initiated legislation to "sunset" the existing Cervical Pap Smear law by 1986.

Substitute 36(A-81)—Adopted
Abolishing Health Systems Agencies
Introduced by George Wilkins, M.D. for Madison County Medical Society

Directed ISMS to support "legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended"; and, as an interim measure, to "introduce a resolution to the AMA House of Delegates urging the AMA to seek a legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with Federal SHPDA designated criteria."

Sub. 40(A-81)—Adopted in Lieu of 40(A-81) & 41(A-81)
Tax Credits or Deductions in Lieu of Direct Reimbursement for Treatment of Public Aid Recipients
Introduced by Dorothy Hubler, M.D. for Clark County Medical Society
Tax Consideration for Care of Medicaid and Medicare Patients
Introduced by Ronald M. Severino, M.D. for DuPage County Medical Society

Mandated that ISMS approve in principle "the concept of amending appropriate state law to provide physicians with the option of taking state income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients"; and directed "that a similar resolution calling for federal legislation, dealing with federal income tax credits or deductions for treatment of medicaid patients, be introduced to the AMA House of Delegates."

Filed the following reports for information: Governmental Affairs Council, Medical Legal Council, Judicial Panel and Department of Registration and Education.

REFERENCE COMMITTEE F

26(A-81)—Referred to Board for Study
Physician Support for President Reagan's Stand on Medical Care
Introduced by Thomas Meirink, M.D. for St. Clair County Medical Society

> Referred to the Board of Trustees for study a proposal that ISMS: (1) Send to President Reagan a letter of appreciation for his decision to oppose all forms of National Health Insurance, and for his wisdom in comprehending the evil that can result from government interference in the practice of medicine; (2) Cooperate with the President in his efforts to prevent the enactment of any NHI plan; (3) Actively support the President's efforts to reduce the involvement of the federal government in the practice of medicine; and (4) Present a similar resolution in the AMA House of Delegates.

34(A-81)—Adopted as Amended
Opposing Increase in 55 mph Speed Limit
Introduced by Ernest Adams, M.D., for Peoria Medical Society

> Mandates ISMS to "go on record as opposing an increase in the 55 mile per hour speed limit."

37(A-81)—Adopted
ISMS Assistance to Medical Staffs in Negotiations with Hospital Boards
Introduced by Edward Fesco, M.D. for LaSalle County Medical Society

> Mandates the Board of Trustees to develop a resource within the appropriate council to "provide information and expertise to hospital medical staffs, to equip physicians by education and training to appropriately represent themselves in dealing with hospital boards and administrations."

Filed for information the following reports: Illinois Foundation for Medical Care, Council on Public Relations and Council on Affiliate Societies

SPECIAL ACTION

The House also adopted a special memorial resolution in memory of William M. Lees, M.D., former chairman of the ISMS Board of Trustees, ISMS second vice president and president of the Illinois Council on Continuing Medical Education, who had died on March 28, 1981, after a long illness. The memorial resolution cited Dr. Lees' pre-eminence in academic and professional areas of medical practice, public service efforts and the many hours he devoted to further advance the standards of medical care.

ELECT OFFICERS, TRUSTEES, AMA DELEGATES

Election of Officers

Dr. Fred Z. White, Chillicothe, was installed as ISMS president, succeeding *Dr. Herschel Browns,* Evanston.

At the concluding session of the House, 1980-81 officers were elected unanimously. They are: *Cyril C. Wiggishoff, M.D.,* Chicago, president-elect; *Robert P. Johnson, M.D.,* Springfield, 1st vice president; *Maynard Shapiro, M.D.,* Chicago, 2nd vice president; *Eugene P. Johnson, M.D.,* Casey, secretary-treasurer; *Clifton L. Reeder, M.D.,* Chicago, speaker of the house and *Julian W. Buser, M.D.,* Belleville, vice speaker of the house.

Election of Trustees

Elected trustees were: *John J. Ring, M.D.,* first district; *Morris T. Friedell, M.D., Henrietta Herbolsheimer, M.D.,* and *Lawrence L. Hirsch, M.D.,* third district; *Robert R. Hartman, M.D.,* sixth district; *Warren D. Tuttle, M.D.,* ninth district and *Thomas Meirink, M.D.,* tenth district.

Judicial Panel

Eugene P. Johnson, M.D., Casey, was elected to another term on the ISMS Judicial Panel and *Allison Burdick, Jr., M.D.* was chosen to complete the unexpired Judicial Panel term of *Howard C. Burkhead, M.D.*

1982-83 Illinois AMA Delegates

The House of Delegates elected AMA delegates and alternates to serve January 1, 1982 through December 31, 1983. Elected delegates were *Herschel Browns, M.D., Howard C. Burkhead, M.D., Jack L. Gibbs, M.D., Theodore Grevas, M.D., Morgan M. Meyer, M.D., Maynard I. Shapiro, M.D.* and *Joseph Skom, M.D.* Alternate Delegates elected were *Alfred Clementi, M.D., Allan L. Goslin, M.D., Robert C. Hamilton, M.D., Harold Lasky, M.D., Arthur Traugott, M.D., Ronald G. Welch, M.D., Fred Z. White, M.D.* and *Cyril C. Wiggishoff, M.D.*

No Dues Increase

At the close of the House, *Morris T. Friedell, M.D.*, chairman, ISMS Board of Trustees, announced that no dues increase was anticipated for the coming year. It was further noted that the Interim Session House of Delegates will meet November 7-8, 1981, in Springfield. If it is determined that an interim meeting is not necessary, an ISMS leadership conference will be scheduled for that date. The 1982 Annual Meeting of the House of Delegates was tentatively scheduled for April 18-21, 1982.

ATTENDANCE

The Credentials Committee recorded attendance of the 1981 House of Delegates as follows:

	First Session	Second Session	Third Session
Officers & Trustees	24	20	21
Speaker & Vice Speaker	2	2	2
District 1	5	6	7
District 2	0	1	0
District 3	92	79	78
District 4	10	10	12
District 5	7	7	6
District 6	3	4	6
District 7	4	3	4
District 8	7	7	8
District 9	5	6	6
District 10	4	4	4
District 11	12	12	12
District 12	7	8	9
Intern/Resident	0	0	1
Student	1	0	0
TOTAL	183	169	176

Abstracts of Board Actions

(Continued from page 273)

1982 HOUSE, BOARD MEETING DATES

The following dates and locations were selected for Board of Trustees and House of Delegates meetings in 1982:

HOUSE OF DELEGATES	
Apr. 18-21	Palmer House, Chicago
Nov. 13-14	Sheraton St. Louis, St. Louis
BOARD OF TRUSTEES	
Jan. or Feb.	Washington D.C. or Chicago
Apr. 17-21	Palmer House, Chicago
June 26-27	The Hamilton, Itasca
Sep. 11-12	Arlington Park Hilton, Arlington Heights
Nov. 12-14	Sheraton St. Louis, St. Louis

To avoid conflicts with the annual meeting of the Illinois Academy of Family Physicians, all future spring meetings of the House of Delegates will be held in April.

ISMS GOALS FOR 1981-82

The Board approved a set of 1981-82 goals for the Society and suggested activities to accomplish them. The goals—which will be used to focus ISMS activities and measure progress—will be prioritized by the Board at its next meeting:

- Increase ISMS membership at all levels and in all areas of the medical profession.
- Maximize communication with the membership.
- Evaluate existing and identify potential sources of new direct membership benefits.
- Increase the effectiveness of medical disciplinary mechanisms.
- Establish ISMS as the mechanism through which the unified voice of medicine can be heard on public policies.
- Enhance the public image of ISMS and the medical profession.
- Establish or improve continuing physician educational activities appropriate to fulfilling the membership's socio-economic and scientific needs.
- Establish a direct relationship with the Council of Medical School Deans and with each Illinois medical school and their affiliated programs.
- Maintain involvement with graduate educational programs within the state.
- Make continuing medical education available locally throughout the state so physicians do not have to take time from their practice to compile the necessary CME credits for relicensure.
- Provide financial support to ICCME to assure the quality and accreditation of programs.
- Meet the medical manpower needs of Illinois citizens while retaining free choice for medical school graduates of where and how to practice.
- Improve accessibility, availability and quality of medical care.
- Play an essential role in formulating public policy decisions related to medical care.
- Assure Illinois citizens their health insurance dollars are being utilized in the most cost effective manner.
- Improve the effectiveness of Board members and trustees as members of the Board and as liaison with component societies.
- Evaluate the structures of the state and component medical societies to determine if they are appropriate to meet the needs of the membership.

- Maintain a benevolence fund with minimum assets of $500,000 maintain an ISMS permanent reserve fund with a balance equal to 50% of the preceding year's revised budgeted expenses conduct semi-annual reviews of the ISMS budget and continually monitor the philosophy and performance of the Society's investment advisors and maintain a reasonable level of dues by use of strong fiscal management. Increases, when necessary, should be sufficient to carry the Society through five years. Excess dues in the first few years of the increase should be held in a contingency reserve for use in the latter years of the period.

HOUSE OF DELEGATES RESOLUTIONS

The Board agreed to introduce resolutions at the 1981 Annual Meeting urging the House of Delegates to amend the bylaws to:

- Clarify the role of the State Peer Review Appeals Committee.
- Allow the Board to cancel the interim session of the House of Delegates if there is not sufficient, relevent business.
- Clarify procedures for filling vacancies on the Judicial Panel.
- Change the House resolution deadline from four weeks prior to the meeting to 30 days in advance.
- Bring bylaws into conformity with the Society's revised policy on the autonomy of county medical societies.

In other actions concerning resolutions, the Board voted to:

- Submit to the House an old business report calling for adoption of a substitute resolution—in lieu of Res. 80A-52 and 80I-13—stating that when physicians are involved in human experimentation they should adhere to and affirm these standards: (1) Accepted ethical standards; (2) The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Section 46; and (3) Any appropriate Illinois Statute or regulatory requirement.
- Introduce a resolution urging the House to: (1) Approve the concept that ISMS recommendations of drugs to be included in the IDPA Drug Manual be based upon effectiveness, rather than cost; (2) Inform IDPA that—while physicians will continue to be cost conscious in all aspects of medical care—this care must be based upon therapeutic considerations; and (3) Urge IDPA to consult ISMS regarding potential problems raised in the Department's cost containment proposal.

The Board will submit a resolution at the 1981 Interim Meeting calling for adoption of a policy on "Active Treatment of Mental Disability."

CME ACCREDITATION

ISMS will explore the feasibility of obtaining accreditation to grant Category 1 credit for CME programs and seek accreditation authority. The accreditation would allow ISMS more freedom in formulating educational programs and eliminate the need to secure co-sponsors for programs in order to offer Category 1 credit.

To ensure the uniform evaluation of CME programs, the Board adopted the following guidelines to govern appointments to the ISMS Committee on CME Accreditation:

- Each member of the ISMS Committee on CME Accreditation should possess a degree of expertise in continuing medical education gained from either (a) service as a CME planner in a community hospital or medical society or medical school, or service as an Illinois CME surveyor; or (b) other training or experience that provides insight into the elements of an effective learning program for medical practitioners.

ADMINISTRATIVE MATTERS

Acting on administrative matters, the Board:

- Recommended that the Educational & Scientific Foundation allocate up to $2,500 from its Publications Improvement Fund for a limited *Illinois Medical Journal* readership survey.

- Continued to retain Winston & Strawn as the Society's legal counsel.
- Discontinued ISMS membership in the U.S. Chamber of Commerce citing a proposed increase in annual dues from $500 to $2,700 over the next three years.
- Declined an invitation to have the Educational & Scientific Foundation receive and administer a foundation grant on behalf of the Crisis Prevention Institute, Inc.
- Approved for distribution to hospital medical staffs a set of guidelines—developed by ISMS legal counsel—focusing on legal considerations involved in drafting medical staff bylaws. The guidelines also will be published in the *Illinois Medical Journal.*

APPOINTMENTS/NOMINATIONS

Mr. Alexander Lerner, Chicago, was named the Society's chief administrative officer, succeeding Mr. Roger White who is retiring. Mr. White will continue to serve ISMS as a consultant until June 30.

Third District Trustee **Dr. Morris Friedell,** Chicago, was re-elected Board Chairman. Named chairmen of Board committees were: **Drs. Jere Freidheim,** Chicago—Finance Committee; and **Alfred Kiessel,** Decatur—Policy Committee.

The following were appointed to the ISMS Panel for the Impaired Physician: **Drs. William Rouse,** Rockford; and **Violet Eggert, Mary Joan McCabe** and **Craig Showalter,** all of Chicago.

Dr. Marshall Falk, dean of the Chicago Medical School, was nominated for appointment to the Illinois Hospital Licensing Board . . . and **Drs. Morris Friedell,** Chicago, and **Edward Cannady,** Belleville, were appointed ISMS representatives to the Illinois White House Conference on Aging, May 27-28, in Urbana and **Dr. Lawrence L. Hirsch,** Chicago, was nominated for appointment as an ISMS representative on the ICCME Board of Directors. ◀

Pediatrician

Board-Eligible or Certified

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(312) 843-7214

Southern Illinois Office
W. J. NATTERMANN
Suite 580, One North Old Capitol Plaza, Springfield 62705
(217) 544-2251

Pulse of the ISMS Auxiliary

ISMSA President's Address

By Mrs. Harold Keegan/Kankakee

The following is the text of Mrs. Harold Keegan's inaugural statement as 1981-82 ISMSA president.



1981-82 ISMSA Board

Seated (L-R) Mrs. Irvin Blumfield, Mrs. Selig Hodes, Mrs. Don Hinderliter, Mrs. Harold Keegan, Mrs. Julian Buser and Mrs. Robert Webb.

Standing (L-R) Mrs. M.W. Hollowell, Mrs. Harlan Failor, Mrs. Louis Tisovec, Mrs. William Hodges, Mrs. James Wilson, Mrs. E. William Lowry, Mrs. Wayne Kassel, Mrs. George Olander, Mrs. Karl Reddies, Mrs. John McLean, Mrs. Norman Taylor, Mrs. Stewart Mauch, Jr., Mrs. Robert Reardon, Mrs. Fred Nathan, Mrs. Francis Graft, Mrs. Charles VanGorder, Mrs. Louis Tarsinos and Mrs. Barrett Dick.

Board members not pictured above: Mrs. Gamil Arida, Mrs. Robert Richardson, Mrs. Morris Friedell, Mrs. Paul R. Stanley, Mrs. Gerald Fox, Mrs. John Simonaitis, Mrs. Robert Rockey, Mrs. J.D. Winterhalter, Mrs. Leslie Lindberg, Mrs. Alex Spadoni, Mrs. Jack Brodsky, Mrs. Ronald Severino, Mrs. Gene Hoerr, Mrs. Alan Taylor, Mrs. J.A. Santiago.

1980 brought us the beginning of a new decade, one which offers promise in these troubled times. There is so much to accomplish in the year ahead, that I, as your president, have chosen to continue walking down the Yellow Brick Road—by *"taking one step at a time."*

We auxilians are a unique group of individuals who have certain responsibilities to our communities, not because we are privileged but because we as physicians' spouses choose responsibility. We stand as a strong voice in many ways. We have the ways and means to accomplish many tasks. Each task can take us down several roads. By *"taking one step at a time,"* we can be sure to

fulfill needed ends.

As your President, in this year ahead, I will emphasize strong organization. My goal, and I need your support, is to accomplish procedure so we may become fully organized. In order to stress continuity, your state auxiliary will devote as much help as needed to develop full potential in county leadership. In order to take this "one step," there will be leadership seminars in September and November and a leadership confluence in October. However, we will not stop there. Your state auxiliary intends to pursue strong organization and will look toward suggestions and ideas to build our state and county image and function to its potential.

We are 3,000 strong in Illinois; 80,000 strong nationwide. We definitely are a voice to be heard. With such a membership, we can influence not only legislation but also the notion of wellness in the minds of persons-at-large.

Wellness, too, is an ongoing educational project. It is "one step" where we will always leave footprints. Wellness promotion remains primary. Projects such as Shape Up For Life, CPR instruction, nutrition awareness, Vial of Life, mental health and immunization are some of our ongoing activities. As your president, I will strive to find new ways and means to bring these and other wellness activities more into the spotlight.

As ever, your auxiliary will remain active in support of AMA-ERF. This "one step" remains an important priority in our medical family. With escalating costs in medical education, our fund raising will become even more necessary. We auxilians are in a position to create new and more effective methods to insure monies for AMA-ERF.

1981 also brings us the Year of the Disabled, something that is special to me. I hope to give emphasis to the program through our auxiliary. If approved for the fall conference, we will hold in October an evening of entertainment and education. There will be a youth game, an OktoberFest with food and drink, and speakers from the Olympics and Special Olympics. This fun, fitness and information event will be held in Wilmette, Illinois.

I'm excited to be your president this year and am looking forward to working with you. So get your shoes ready. Before you know it, by *"taking one step at a time,"* we just might find ourselves covering more ground than we planned. Wouldn't that be wonderful?

It is my pleasure to dedicate this auxiliary year to my daughter, Kim. ◀

How do you manage anorectal barbed fire?

95% of colon/rectal surgeons surveyed* add TUCKS® pads concomitantly to preferred suppository/ointment/cream medication for best results...

In Acute Hemorrhoidal Flare-up Prescribe Anti-inflammatory

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suppositories/cream
with hydrocortisone acetate...

the #1 prescribed product** for external and internal hemorrhoids and other common anorectal disorders

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Tucks®

The #1 premoistened hemorrhoidal pad* for added external relief and gentle cleansing of fecal residue that can irritate tender anorectal tissue.

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

PD 400-JA-0146-P-1 (1-81)

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads
Hemorrhoids and other anorectal uses–TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene. Used on outer rectal areas, they remove residue that can bring on more irritation. Pads are premoistened with 50% witchhazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.
Vaginal Uses–Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate
ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate
Caution: Federal law prohibits dispensing without prescription.
Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
Anusol-HC Cream–one-ounce tube (N 0071-3090-13) with plastic applicator.
Store between 59°-86°F (15°-30°C).
1089G010

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EKG

(Continued from page 280)

Answers: 1. D, E 2. E

This tracing is difficult because the P waves of the premature atrial beats are difficult to see, which is a common problem. A careful examination of the area of the ST segment is important. In the first three conducted beats of the first strip, the ST segment is deformed sharply when compared to the ST segment of the next two beats. There is an ectopic P wave buried on top of the ST segment in these first three beats. The ectopic P waves in bigeminy fail to conduct. The ectopic P waves may be easier to see when they do conduct. The seventh and eighth beats of the second strip have a widened QRS. A careful scrutiny of the ST segment preceding these two beats shows the small notch of the ectopic P wave. These two beats show aberrant intraventricular conduction. The P wave configuration of premature atrial beats is different from the sinus P wave and related to the ectopic site on the atria. The PR interval of the premature atrial beat is related to the refractoriness of the atrioventricular (AV) node. A premature atrial beat that occurs very early in the cycle will find the AV node still refractory from the preceding sinus beat. AV nodal disease can also prolong the AV refractory period. The return cycle or the cycle following the ectopic P wave is longer than a sinus cycle and less than two sinus cycles, *i.e.*, not a compensatory pause. The difference between the non-compensatory return cycle and the sinus cycle has been used to calculate the sino-atrial conduction time. The basic sinus rate here was 75 beats per minute. The third, fourth, and fifth beats of line three and the second, third, and fourth beats of line four occur at a rate of 95 beats per minute. A careful examination of these beats shows ectopic P waves at a rate 190 per minute conducting with a two to one ratio. These are short bursts of atrial tachycardia with 2:1 AV block.

All of the statements in the second question are true. Premature atrial beats can often lead to atrial tachycardia, atrial flutter, or atrial fibrillation. They often respond to treatment for congestive heart failure. However, non-conducted premature atrial beats can also be a clue to digitalis toxicity. The etiology of the arrhythmia in our patient was not determined but it responded to relatively low doses of quinidine. ◀

OBITUARIES

***Allen, Hubert Lee,** Alton, died March 12, 1981, at the age of 71. He was a 1936 graduate of Tulane University School of Medicine, New Orleans. During his medical career, Dr. Allen served on the staff of St. Joseph Hospital, Alton, from 1941-76.

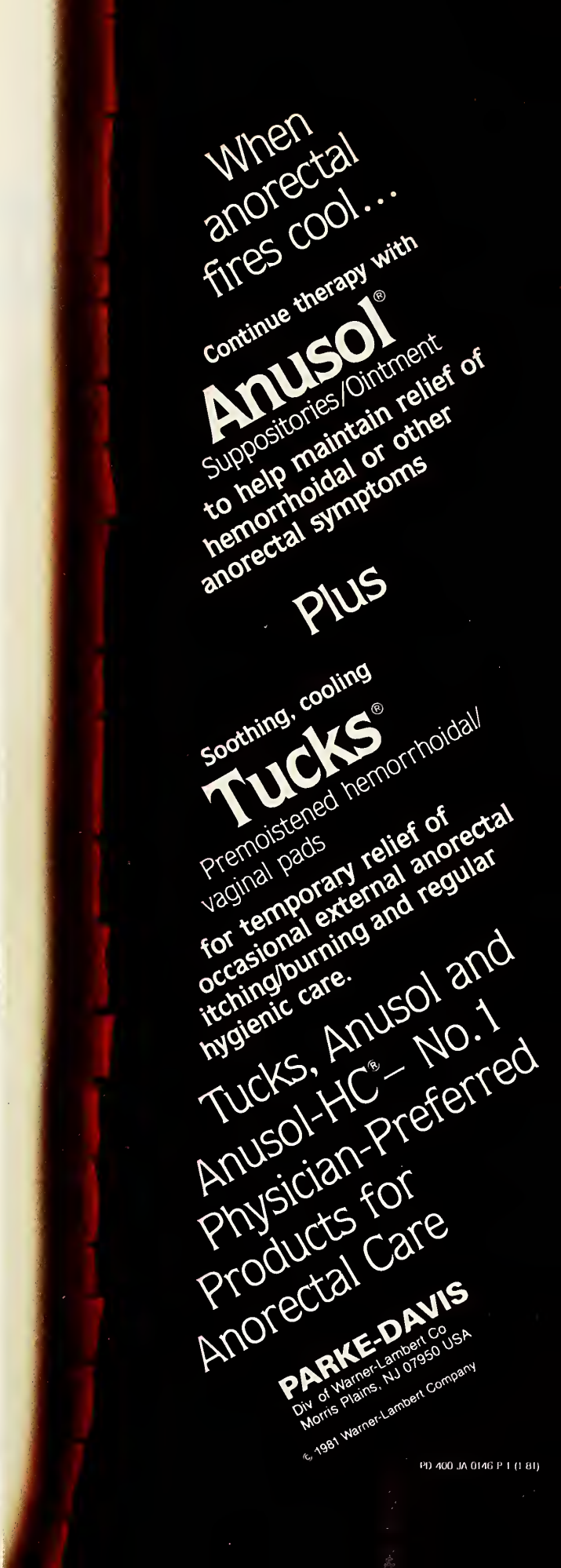
***Errico, Silvio,** Moline, died March 28, 1981 at the age of 71. He was a 1936 graduate of the Chicago Medical School and had been affiliated with the Moline Public Hospital since 1938. Dr. Errico was also a former president of the hospital medical staff and chairman of its executive committee.

***Robinson, Benjamin,** Urbana, died April 9, 1981, at the age of 58. Dr. Robinson graduated from the University of Colorado School of Medicine in 1949.

***Rohde, Walter,** Fisher, died March 22, 1981 at the age of 61. He was a 1941 graduate of Wurzburg University, Wurzburg, Germany.

****Rosenbaum, Harold,** Chicago, died March 15, 1981 at the age of 91. After graduating in 1916 from Rush Medical College, Dr. Rosenbaum had been affiliated with Children's Memorial Hospital in Chicago.

* Indicates ISMS member
**Indicates ISMS member of the fifty year club



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Membership Forum

Membership Forum is intended to serve as a communication tool for ISMS Membership. The Editors encourage comment and criticism on issues of the day. Material published in this section reflects the personal opinions of individual ISMS members. ISMS cannot accept responsibility for content. Publication does not reflect official policy or position of the Illinois State Medical Society or the Illinois Medical Journal. The right to edit materials, which should be limited to 300 words or less, is reserved.

Correspondence should be addressed to: IMJ, 55 E. Monroe, Suite 3510, Chicago 60603.

On Hearing Aids

To the Editors:

While the National Hearing Aid Society (NHAS) commends the intent and most of the contents of the article "Hearing Aids" in the December issue of *IMJ,* (Vol. 158, No. 6, pages 392-394) there are some inaccuracies we want to correct.

The article characterizes hearing aid specialists in a derogatory way as "businessmen," as though that somehow makes them less than professional. The hearing aid specialist is a businessman the same as any professional who is paid for his services, including doctors. Hearing aid specialists are professionals, and have been recognized as such by the Food and Drug Administration (FDA).

To refer to the hearing aid specialist who renders in-home sales and services as a "door-to-door salesman" is inaccurate. Calls away from the office fill an essential need of the hearing impaired who are unable to travel. They are made by invitation. Literally thousands of home-bound hearing impaired have written to the FDA pleading that any possible ruling not disrupt the in-home calls of their hearing aid specialists.

The article incorrectly states: "Dealers often called themselves certified hearing aid audiologists until federal legislation forbad this practice. Certification was by the industry, not any public body." The term "audiologist" has been in use since 1935 to describe those involved in auditory prosthesis (hearing aids). It has evolved into a generic term describing those engaged in the science of hearing, and is properly used with a modifier such as "clinical," "medical," or "hearing aid" to distinguish which branch of hearing.

The professional designation of Certified Hearing Aid Audiologist has been used since 1948 to make qualified persons easily identifiable to the public. There is no federal legislation forbidding the use of the title, nor is it unusual for a professional organization, like NHAS, to be the certifying body. NHAS is an association of professional persons involved in the science of hearing. Certification is conferred only to those who have met exacting requirements of experience, education, examination, endorsement, ethics, and peer review.

Sincerely,
Anthony DiRocco
Executive Vice President
National Hearing Aid Society

Editor's Note: *Mr. DiRocco's comments were supported by a brief note from the Illinois Society of Hearing Aid Specialists. That letter advised that Mr. DiRocco's comments expressed mutual concerns. The authors' response follows.*

The Authors Respond

To the Editors:

The main purpose of the article was to inform primary care physicians that help for their hearing impaired patients can be effectively obtained in many cases. With that in mind, I would like to address some of the issues Mr. DiRocco raised.

The Federal Trade Commission states (FTC Hearing Aid Industry Staff Report Summary issued November 1978 S. 440.8 Your Title) that an audiologist is someone who: (1) has been certified as an audiologist by the American Speech (Language) Hearing Association; or (2) currently meets, or at one time, met all of the educational, experience, and testing requirements for an ASHA certificate; or (3) has a graduate degree in audiology and is qualified as an audiologist under state law.

In my opinion, use of the term audiologist to describe or identify someone who is not could mislead the consumer.

The FTC summary report pointed out that the NHAS (National Hearing Aid Society—identified as the retailer's organization) certified as competent those of its members who passed its 20 week home study course, have had two years of experience in the business, and can obtain the necessary endorsements from a physician and from two other certified NHAS members. The FTC found in their comprehensive three-

year study that less than one-third of all retail salespersons were so qualified.

I am pleased to see more audiologists dispensing. All of our combined efforts can help to serve the hearing impaired. The more knowledge the hearing impaired consumer possesses, the greater his ability to make informed choices.

Sincerely,
Jerry Owens, M.A., CCC
Audiologist
Decatur

Some Views On Categorization

To the Editors:

I am constrained to reply to the editorial in the January issue of *IMJ,* (Vol. 159, No. 1, pages 19-21) written by my good friend, Dr. Morris Friedell, on regionalization of medical care. He has indeed presented a thoughtful analysis of the perplexing problems that our increasingly intricate and technologically oriented society has thrust on our attempts at delivering optimal care to the most people. Two points should be made to indicate the complexity of the situation inherent in Dr. Friedell's remarks.

First, in a Commentary in the Journal of the American Medical Association, Vol. 24, No. 16, P. 1723 written by Frey, *et al.,* they state, "Recent reports indicate that 20% to 30% of patients with potentially salvageable injuries who are delivered alive to hospitals die unnecessarily." Further "In addition to errors in evaluation and management, the preplanning, mobilization, and organization of hospital staffs and facilities necessary for the care of such patients are often inadequate."

Second, Dr. Friedell quotes figures of 1500 deliveries per year and 75% bed occupancy as an example set in the joint report of the American Medical Association, the American College of Obstetricians and Gynecologists, American Academy of Family Practitioners, and American Academy of Pediatrics relating to minimum requirements of an optimal maternity hospital. Those numbers were discarded some months ago by the Departments of Health of the State of Illinois, and the City of Chicago as it was recognized that these "number games" had no necessary relationship to the quality of maternal and infant care rendered by a hospital so much as its staff and facilities.

This was spelled out in an article written for Chicago Medicine by the undersigned in Vol. 82, No. 22, November 21, 1979. We are all agreed that an ideal society should provide the best medical care to all its inhabitants. The problem obviously lies in finding the least expensive, least traumatic, and most direct route to that end.

Sincerely yours,
Alex S. Tulsky, M.D.
Chicago

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Motrin® vs aspirin w/codeine..
(ibuprofen)

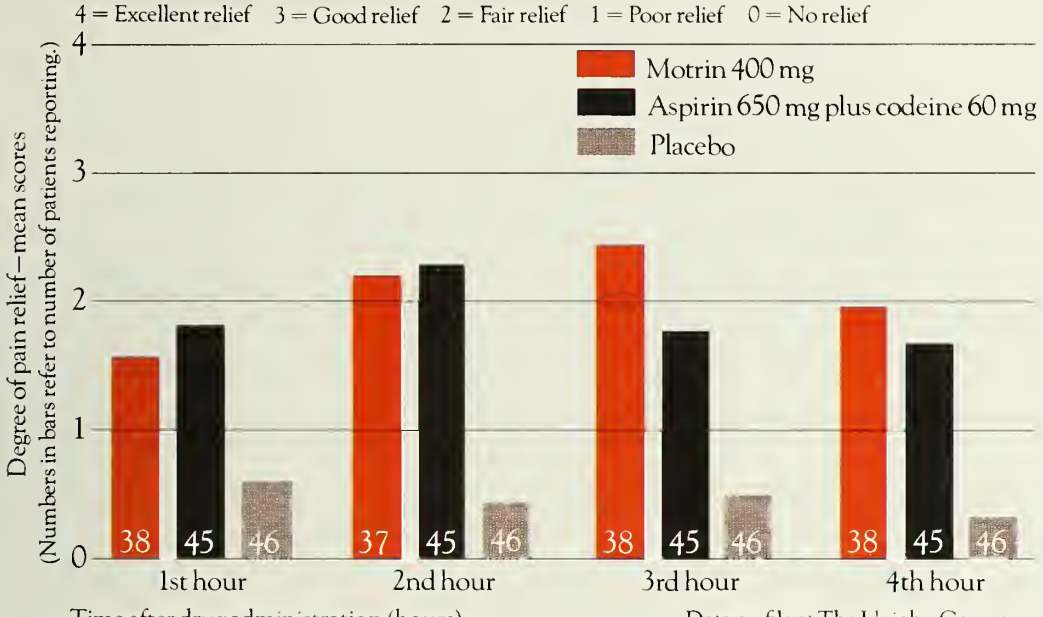


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compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients. In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval. Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief
Motrin vs aspirin-codeine combination



Data on file at The Upjohn Company.

One tablet q4-6h prn
For relief of mild to moderate pain:

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ibuprofen, Upjohn

• Not a narcotic • Not addictive • Not habit forming • Nonscheduled • Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

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Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. *Aspirin:* Used concomitantly may decrease Motrin blood levels. *Coumarin:* Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy nor by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400, or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

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MED B-4-S

Clinics for Crippled Children Listed for June

Forty clinics for Illinois' physically handicapped childre have been scheduled for April by the University of Illinoi Division of Services for Crippled Children. The clinics pr vide diagnostic orthopedic, pediatric, speech and heari examination, along with medical, social and nursing ser ices. There will be 26 general clinics, 11 cardiac clinics tw for myelodysplasia and one clinic for children with neur logical problems. Any private physician may refer to bring to a convenient clinic any child or children for who he may want examination or consultative services.

1 Peoria Myelodysplasia—St. Francis Medical Center
2 Maryville—Oliver C. Anderson Hospital
2 Park Ridge Cardiac—AM—Lutheran General Hospital
2 Park Ridge General—PM—Lutheran General Hospital
2 Wheaton General—Marianjoy Rehab. Hosp.
3 Carmi—Carmi Township Hospital
3 Springfield Ped-Neuro—St. John's Hosp.
3 Hinsdale—Hinsdale Sanitarium
4 Sterling—Community General Hospital
4 Lake County Cardiac—Victory Mem. Hosp.
5 Division Cardiac—U. of I. at the Medical Center
8 Peoria Cardiac—St. Francis Medical Center
8 Belleville—Belleville Memorial Hospital
8 Chicago Heights Cardiac—St. James Hosp.
8 Maywood—(Orth/Ped/Neuro)—Loyola Medical Cent
9 East St. Louis—Community Hospital
10 Champaign-Urbana—McKinley Health Service Center
10 Chicago Heights General—St. James Hosp.
10 Joliet—St. Joseph's Hospital
11 Rockford—St. Anthony Hospital
11 West Frankfort—United Mine Worker's of America Union Hospital
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11 Kankakee General—St. Mary's Hospital
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16 Rock Island Area General—Moline Public Hospital
16 Decatur—Decatur Memorial Hospital
17 Aurora General—Mercy Center for Health Ca Services
18 Springfield General—St. John's Hospital
18 Bloomington—Mennonite Hospital
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19 Kankakee Cardiac—St. Mary's Hospital
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22 Maywood—(Orth)—Loyola Medical Center
22 Chicago Heights Cardiac—St. James Hosp.
23 Peoria—St. Francis Medical Center
24 Chicago Heights General—St. James Hosp.
24 Elgin MM—Sherman Hospital
25 Anna—Union County Hospital
26 Evanston—St. Francis Hospital
29 Peoria Cardiac—St. Francis Med. Center

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IMJ Attention

NEW ISMS EXECUTIVE ADMINISTRATOR NAMED — Mr. Alexander R. Lerner, Chicago, has assumed the post of ISMS executive administrator, succeeding Mr. Roger N. White, who has retired. The appointment was made by the ISMS Board of Trustees during the Society's annual meeting. Mr. Lerner was president of Governmental Affairs, Inc., a consulting firm advising public and private sector groups on government relations and implementation of administrative policies. A former ISMS staff director, Mr. Lerner had previously served as assistant director of the AMA Department of Federation Affairs and deputy manager of Governor Thompson's 1978 re-election campaign.

JUBILANT NEWS FROM SPRINGFIELD — ISMS made major progress in the malpractice arena this month. Three crucial bills to protect physicians' rights in malpractice suits have passed Committee. On Wednesday, April 29, the House Judiciary 1 Committee forwarded HB 1029, HB 1155 and HB 1365 to the general assembly.

HB 1029, sponsored by Lee Daniels (R-Elmhurst) would require proof that the result obtained from treatment would not have ordinarily occurred in the absence of negligence, in order to invoke the *res ipsa loquitur* ("the thing speaks for itself") doctrine in medical malpractice cases. The Committee passed HB 1029 by a 12/0 vote.

HB 1155, introduced by Rep. Sam Vinson (R-Clinton) is intended to counter the drastically escalating cost of professional liability insurance. The Committee forwarded this bill to the floor by a vote of 11/3.

HB 1365, sponsored by Rep. Lee Daniels (R-Elmhurst) would amend the Medical Studies Act to include hospital medical staff committees among the data-generating entities whose reports are protected from discovery.

Two other bills relevant to malpractice are HB 1255 and SB 273. HB 1255 would have provided for automatic one year suspension of medical license when a physician is convicted of malpractice for the second time, or reaches a second out-of-court settlement in a malpractice case. Rep. Jill Zwick (R-Dundee), the sponsor of HB 1255, agreed not to call the bill after listening to ISMS objections. SB 273 would have limited the use of expert witnesses in medical malpractice cases. The sponsor, Sen. William Marovitz (D-Chicago), has also agreed not to pursue passage of that bill.

A bill to provide for independent nurse-midwives, sponsored by Rep. Richard Mautino (D-Spring Valley), was defeated by a vote of 9/3 in the House Health and Family Services Committee. Associations joining ISMS in opposition to that bill included the American College of OBGYN, American Hospital Association and the Illinois Nurses Association.

Finally, an update on the chiropractic bills: SB 242, which would have required mandatory inclusion of chiropractic insurance benefits in all BCBS policies, passed out of the Senate Public Health, Welfare and Corrections Committee and now awaits action on the Senate floor. Two similar house bills that were introduced, HB 1142 and 1526, were not called by the sponsor, Rep. Ronald Stearney (R-Chicago).

MALPRACTICE SUITS UP — A record 833 malpractice suits were filled against Cook County physicians in 1980, a 10% increase over the previous high of 758 filed in 1975. Malpractice suit filings had dropped in 1976-77, but increased by 20% in 1978 and 48% in 1979. There is no reporting system which enables an assessment of statewide litigation trends.

DISCIPLINARY RULES ADOPTED — Rules and regulations pertaining to the functioning of the Illinois Department of Registration and Education Medical Disciplinary Board have been promulgated. These identify the scope of activity of the Board, as well as procedures for processing complaints and discipline. Included in the regulations are such matters as guidelines relating to advertising, informal conferences, time limits within which matters must be processed and emergency suspensions. These rules have been published in the "Illinois Register." Persons interested in obtaining a copy of the rules may request one by writing either the Illinois Department of Registration and Education, 320 W. Washington, Springfield 62786 (217-785-0822); or ISMS, Division of Publications, Medical-Legal and Mental Health, 55 E. Monroe, Suite 3510, Chicago 60603 (312-782-1654).

JAIL HEALTH PROGRAM PROGRESS — The Campaign County Jail, Urbana, recently became the first Illinois county correctional facility to receive two-year national accreditation of its health care system.

One of 16 Illinois county jails participating in the Illinois Jail Health Program, the Champaign County Jail received its accreditation after an ISMS technical advisory committee surveyed its system and submitted recommendations to the AMA Advisory Group on Accreditation.

Accreditation is a secondary goal of the Illinois Jail Health Program, which seeks to upgrade health care services in county correctional systems. The program involves ISMS assistance to jail personnel who work to meet AMA standards for health care, including screening for contagious disease, regular and emergency care provisions, and treatment of alcohol and drug related problems.

NEW JUDICIAL COUNCIL GUIDELINES PUBLISHED — A new volume, replacing the *AMA Judicial Council Opinions and Reports*, is now available. A companion to the Principles of Medical Ethics adopted at the 1980 AMA Annual Meeting, *Current Opinions of the Judicial Council of the AMA* replaces an earlier volume. It discusses such issues as quality of life, terminal illness and allocation of health resources by physicians.

The new volume may be obtained by writing OP-122, AMA Order Dept., PO Box 821, Monroe, WI 53566. Costs are $4 each for up to 10 copies; $3.50 each for 11-49 copies; $2.75 each for more than 50 copies and $5 each for copies sent to other countries.

ELIGIBILITY REQUIREMENTS CHANGED — The Advisory Committee on Continuing Medical Education of the AMA Council on Medical Education has adopted revised eligibility policies for the Physician's Recognition Award. All physicians who hold a valid and current license issued by a US licensing jurisdiction, or are engaged in residency training in an accredited US program, may now apply for the award.

HCFA RECOGNIZES JCAH — Amended Health Care Financing Administration regulations, designed to achieve greater uniformity and less duplication, certify that JCAH institutional planning standards for hospitals are equivalent to the Medicare institutional planning requirements. JCAH-accredited hospitals will no longer be required to undergo state agency review, except for validation surveys. (The HCFA report states that validation surveys are conducted only on some accredited hospitals to determine that they do, in fact, meet standards.)

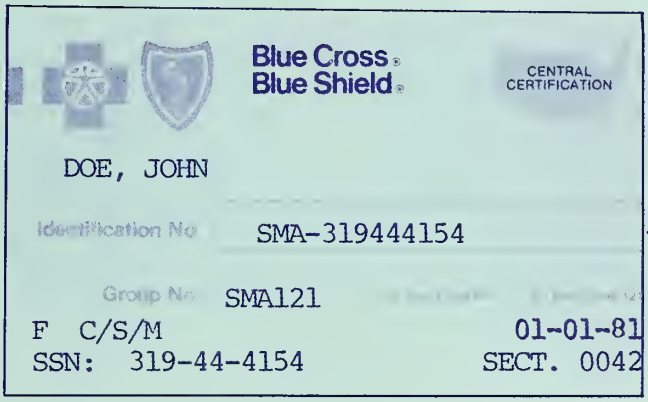
SUCCESSFUL HYPOTHERMIA TREATMENT REPORTED — Physicians at the University of Chicago have successfully demonstrated a technique to save the lives of ill and elderly persons suffering from hypothermia. The procedure involves rapid rewarming in water circulating at 104°F. and UC statistics report that 19 of 20 accidental hypothermia patients rewarmed with this method have survived. More information about the total procedure may be obtained through James S. Sweet, University of Chicago Public Information Office: (312) 753-4433.

Blue Cross®
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REPORT

FOR *Illinois Physicians*

Blue Cross and Blue Shield Central Certification Coverage A Guide for the Health Care Provider



Subscriber's Name —

Group Number —

Subscriber's Identification Number

Be sure to give your local Blue Cross and Blue Shield Plan these three pieces of information!

What is "Central Certification?"

The "Central Certification" program was developed to provide uniform benfits and services to certain Blue Cross and Blue Shield members.

It is primarily used to handle the employees of a company that has all of its personnel, payroll and health coverage records in one location, but whose employees are located at plants and offices in different states, or they travel a great deal or change location frequently.

Since all Blue Cross and Blue Shield Plans in the nation-wide system may not have the exact same benefits, Central Certification was established to provide standard coverages for national companies.

All records are kept by one Plan, commonly referred to as the "Control Plan," which is usually located in the insured company's headquarters city.

The control Plan issues special identification cards bearing an outline of the United States to all employees of that company, regardless of the location.

However please be advised that a Blue Cross and Blue Shield member carrying a Central Certification card should be treated just like any local member. The Central Certification card should be accepted just the same as a card from the local Plan.

THE CARD

The Central Certification Card — similar to the sample at the top of the page — is different from the regular Blue Cross and Blue Shield identification card. Along with the member's name and identification number, the card also contains a six-character Group Number. The three letters identify the company where the member works and the three numbers identify the Blue Cross and Blue Shield Control Plan.

WHAT YOU DO

When a central certification subscriber comes to you for care, treat the patient exactly as you would any other Blue Cross and Blue Shield member. Give your local Plan:

the name:	John Doe
the identification number:	SMA-319444154
the group number:	SMA 121

The local Plan will then process the claim for that member.

Special Note: Report both outpatient cases and inpatient cases to your local Blue Cross and Blue Shield Plan. Most Central Certification members have comprehensive coverage, including outpatient benefits.

After the patient is discharged, or has received outpatient services, the local Blue Cross and Blue Shield Plan will reimburse you just as it would for any of its local subscribers.

PLEASE REMEMBER

Central Certification is a great convenience for a company with employees scattered throughout several states.

In almost all cases, the patient lives and works in your community.

Just remember that the Central Certification member — as you're concerned — is exactly the same as any local Blue Cross and Blue Shield member.

You deal only with your local Blue Cross and Blue Shield Plan.

You will be paid by the local Blue Cross and Blue Shield Plan.

PLEASE NOTE!

There are several major Central Certification groups that have Blue Cross only cards. Their medical/surgical benefits are covered by other third party carriers. Following is a list of those groups with Blue Cross coverage only and the name of the carrier that covers their medical/surgical benefits. Claims should be forwarded to their carriers for medical/surgical services.

Group Name	Group ID	Carrier
Columbia Broadcasting System	CBS303	Prudential - New Jersey
Eastman Kodak Corporation	EKC304	Metropolitan
General Electric Corp.	GEC	Metropolitan
International Business Machines	90600	Prudential
Owens Illinois Glass	OIG337	Aetna
Time, Incorporate	TLE303	Traveler's
Western Electric Corp.	WER303	Traveler's
Westinghouse Corporation	WXB363	Equitable

HEALTH DEPARTMENT SAYS MEASLES ON DECLINE

The following is a message from the Illinois Department of Public Health:

During the period 1974 - 1977, a steady increase in the incidence of measles was observed. However, during the past three measles seasons (1978, 1979 and 1980) a dramatic decline in reported measles incidence has occurred in Illinois.

Measles morbidity decreased 78.6% (from 1644 cases to 353 cases) in 1980 compared to the same period in 1979. Many factors are undoubtedly involved in this decrease, including the natural periodicity of measles and the exhaustion of susceptibles in some areas. Nonetheless, it is fair to state that the increased level of activity in both immunization service delivery and surveillance outbreak containment have played major roles.

The present programmatic and epidemiologic situation in the United States, as well as Illinois, seems uniquely favorable for the interruption of measles transmission. Measles immunization among school-age children is at the highest level ever. However, in spite of high immunization levels, measles outbreaks are still a possibility. The Center for Disease Control believes that intensive surveillance and rapid outbreak containment procedures can eliminate the indigenous transmission of measles in the United States within a few years.

The private physician plays a key role in the success of this program. As the number of cases continues to decline, every case becomes more important. Therefore, each suspect case of measles should be reported, by telephone, to the Local or State Health Department. A professional epidemiologist will investigate each case to: identify source-spreads and identify susceptibles who might need immunization or immune serum globulin. A follow-up report will be sent to you for your records.

For additional information regarding this program, contact your local Health Department or the Illinois Department of Public Health, Immunization Division, 535 West Jefferson Street, Springfield, Illinois, 62761, (217) 785-1455.

IMJ

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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

Contents of IMJ are listed in the Current Contents/ Clinical Practice

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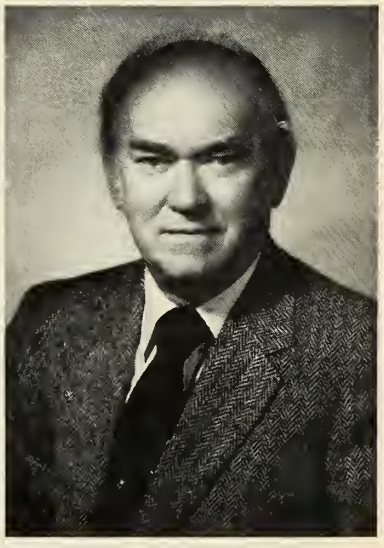
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President's Page



The Price of Principle

When we endorse a principle, we frequently are aware that a "fiscal note" will be attached. That was the case when the House of Delegates recently voted to retain unified membership. The House overwhelmingly supported the principle of a unified voice of organized medicine—county, ISMS and AMA—recognizing several costs were involved.

Had de-unification occurred, individual members would have paid less dues if they chose to discontinue AMA membership. If experiences in other similar states can be accurately extrapolated to Illionis, de-unification might have signaled membership increases for ISMS and county societies. Here—in an open, upfront way—were easily identified costs analyzed and accepted by the House.

In some instances, we have struggled to develop and support principles when the cost was not obvious. In others, we may not have expected acceptance of the principle and, therefore, the resultant cost.

Co-payment is a classic example. We long have supported the principle, but its pragmatic application by Medicaid to office and hospital emergency room visits could pose enormous problems. Another principle favored by many is diminished goverment spending on both the state and federal levels. Again, there are pitfalls. The reduction could affect medical education, hospitals and even physician payments.

If an issue or principle is worthwhile, it must merit financial as well as vocal support. As with unified membership, we must be ready to pay the price of the principle and be sure the principle is worth that price. ◀

Fred Z. White, M.D., President

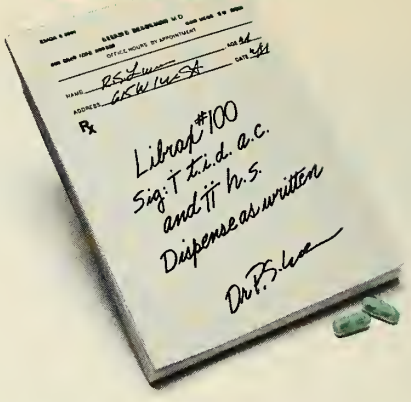
Clinics for Crippled Children Listed for July

Forty-one clinics for Illinois' physically handicapped children have been scheduled for July by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 10 cardiac clinics, one for children with neurological problems and two for myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

1 Hinsdale Sanitarium
2 Springfield General—St. John's Hospital
2 Effingham—St. Anthony Memorial Hosp.
2 Lake County Cardiac—Victory Memorial Hospital
6 Peoria Myelodysplasia—St. Francis Medical Center
7 Quincy—St. Mary's Hospital
7 DuQuoin—Marshall Browning Hospital
7 Danville—Lake View Hospital
7 Belleville—St. Elizabeth's Hospital
7 Park Ridge Cardiac—AM—Lutheran General Hospital
7 Park Ridge General—PM—Lutheran General Hospital
7 Wheaton General—Marianjoy Rehab. Hosp.
8 Champaign-Urbana—McKinley Health Service Center
8 Chicago Heights General—St. James Hosp.
8 Joliet—St. Joseph's Hospital
9 Sterling—Community General Hospital
9 Macomb—McDonough Health Department
9 Kankakee General—St. Mary's Hospital
9 Aurora Cardiac—Mercy Center for Health Care Services
10 Division Cardiac—U. of I. at the Medical Center
13 Peoria Cardiac—St. Francis Med. Center
13 Chicago Heights Cardiac—St. James Hosp.
13 Maywood—(Orth/Ped/Neuro)—Loyola Medical Center
14 East St. Louis—Community Hospital
14 Peoria—St. Francis Medical Center
15 Springfield Ped-Neuro—St. John's Hosp.
15 Aurora MM—Mercy Center for Health Care Services
15 Evergreen Park—Little Company of Mary Hospital
16 Elmhurst Cardiac—Memorial Hospital of DuPage County
17 Kankakee Cardiac—St. Mary's Hospital
20 Maywood—(Orth/Ped)—Loyola Medical Center
21 Rock Island Area General—Moline Public Hospital
21 Alton—Alton Memorial Hospital
21 Decatur—Decatur Memorial Hospital
22 Rockford—St. Anthony Hospital
22 Chicago Heights General—St. James Hospital
22 Elgin General—Sherman Hospital
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The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:
"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Guest Editorial

Ethical and Practical Concerns In Hospice Care

By Lawrence L. Hirsch, M.D./Chicago

The following was first presented as a lecture at a conference on death and dying which was jointly sponsored by ISMS and the American Society of Law and Medicine.

Some years ago, I heard a story that continues to haunt me; it comes to mind whenever the topic of a terminally ill person arises. It is told that when an eskimo reaches the state where productivity is below consumption, the eldest son lovingly places the oldster on a sled and, with his eldest son, finds a relatively sheltered area a few days' travel from the igloo. Here the ailing one is placed with a blanket as threadworn as he; a token amount of food is placed alongside. With tenderness, and in silence, the son and grandson depart. Upon returning home, the youngster is told, "And thus you must do *for* me."



LAWRENCE L. HIRSCH, M.D., is a board certified family physician and fellow of the American Academy of Family Physicians. A past president of the Chicago Medical Society and former first vice president of ISMS, Dr. Hirsch is a member of the ISMS Board of Trustees and an ISMS delegate to the American Medical Association. He is a past president of both the Illinois Academy of Family Physicians and the medical staff at Illinois Masonic Medical Center in Chicago. Dr. Hirsch is affiliated with the Chicago Medical School, where he serves as professor and chairman of the Department of Family Medicine. He is a member of the board of governors for the Illinois State Medical Inter-Insurance Exchange and the board of directors for the Chicago Foundation for Medical Care-PSRO, as well as treasurer of the Association of Chairmen of Departments of Family Medicine.

This brief but moving vignette contains several implicit values which determine ethical positions which, in turn, lead to practical concerns. First is the question of productivity versus consumption. This value occurs in all cultures, although the concept of productivity varies. Reference could be to crafting of tangible items for use in the economy, to representing a source of wisdom and counsel, to signifying a mystic link to the past, or to unique combinations of specific qualities identified over time and lost in time. Consumption becomes a serious concern in situations of marginal or severely limited resources where distribution, especially to the young, forces a decision. Emotional pain is eased by pragmatic action cloaked in ritual and/or custom. I suggest that we in the United States—indeed, all of spaceship Earth—are rapidly approaching this terrifying situation.

Second is the question of filial piety. Without delving into the psychodynamics, or a theologic consideration of this value, I believe that we all recognize the implications of parent/child bonding. Wilson's development and espousal of the new field of sociobiology explains family love on the basis of survival value. He shows that all life

forms tend to display altruism in direct relationship to shared genes. Darwin's formulation is somewhat widened, so that transmittal of genes, and not the phenotype, is fundamental to "survival of the fittest." Next in importance are shelter and food. Separation of these into distinct values is to recognize and emphasize their symbolic significance. One of the unique qualities of man is the ability to manipulate symbols, to place abstracts in a concrete form. Our celebration of life transitions, including our celebration of death, are such symbolic acts. Tradition, customs and ritual are each related to this value.

And finally, we consider perpetuation of the system. Strictly speaking, culture is not heritable, but it does have surviving qualities. Much of the greatness, as well as the problems, of our civilization is due to man's ability to pass on information, from generation to generation, with varying amounts of change. Implicit is the admonition, "If it ain't broke, don't fix it!" I believe, and mean to demonstrate, that the values, ethics, and practical concerns of hospice care are substantially the same as those involved in the purported eskimo tradition.

Briefly, hospice care is a response to the need to attend to the terminally ill and their families. Death is a social, or tribal, event. We try to understand and explain death. It is disrupting, it is mysterious, it is intriguing, it is fearsome. Too often, it generates guilt in those close to the central figure. As in birthing, we are re-discovering a need to participate in an awesome process. The hospice can be of much help in addressing this feeling.

The word hospice derives from the concept of hosting or providing food, lodging, and rest for the traveler. It is akin to hospital, hotel, and hostel. During the crusades, various religious orders maintained hospices along the routes between Europe and the battle areas. In fact, until the modern hospice movement became somewhat more common, the hospice was associated with religious overtones.

A hospice program can be implemented in the home, in a specific area of a hospital, in a skilled nursing facility, or in a special entity. But storm clouds of controversy gather when we look closer and find, perhaps, that there are some value-laden words masquerading as innocent descriptors. How have we established the "need?" What is subsumed under "attending to?" How is "terminally ill" defined? Do we mean nuclear or extended family? Is there a "program" that can really be applied in the various sites enumerated? Our ability to determine the ethical "ought" will depend upon how we answer these and other very sticky questions. Our common, everyday experience, will alert us to the realization that, even if we agree on the "oughts," there are many possible tactics to accomplish these strategies.

Specifically, what services should be available in the hospice? If the objective is to make the dying process comfortable—physically, emotionally, socially, and financially—we shall have to be critical of the "do everything" mentality. Not too long ago, the physician's armamentarium was severely limited and pitifully ineffective. Under such conditions, it was understandable that "everything" should be done. It was implied that the patient should not be ignored, that the ritual of care and caring should be meticulously followed, and that the exercise was a preparation for the inevitable death. Technology has progressed much more rapidly than has the public's appreciation of that change. The media have been unable to present miracle-like events in their true perspective. The same words, "everything should be done," now mean something quite different; they seem to demand the miracles so glowingly chronicled by feature writers. Undoubtedly, inability to fulfill this expectation is part of the cause of hostility toward physicians.

If we can truly identify the person who will be dead in a year or less, regardless of medical intervention, and if the patient and the family understand the circumstances, and if all are amenable to a given program, then the hospice can be brought into action. In each case, we must determine how much of an "active regimen" will be continued. Hospice programs should not be equated with a cessation of treatment that has been found to be meritorious. Radiation, antimitotics, and other agents that have significant unpleasant or noxious side effects should be carefully weighed against their positive potential and, if found wanting, discontinued.

Both physicians and patients place a high value on freedom from, or relief of, pain. It is commonly accepted that the physician ought to prescribe appropriate medication in adequate amount to obtund pain. Narcotics, the best pain relievers, cause respiratory problems, constipation, and some torpor. I refuse to consider the question of possible addiction in the terminal patient. Practically, is this stance justified? I think so. Although there is much controversy, I am convinced that a person who takes a narcotic for pain is unlikely to become addicted. If the narcotic is taken for the euphoric effect, addiction is almost inevitable. In either case, in the *terminal,* or dying patient, I believe that addiction is not an ethical, or medical, problem.

But to what extent should a patient be "snowed under?" Granted that various combinations of non-narcotics can be used, and that mixtures of narcotic extenders are valuable, there often comes a time when heavy doses of physiologic depressors are necessary to control pain. Clinical judgement coupled with good rapport must be determinants.

I have some serious reservations as to the appropriateness of intensive speech therapy, repeated laboratory determinations, and frequent modification of medical management. The basic premise, if you recall, is that a hospice is to serve the terminal patient, the person who has been carefully evaluated and found to be beyond the curative power of modern medicine. What remains to be done is twofold: ease the dying process, and help the family to cope.

Invariably, people talk of "death with dignity." Too often, this value becomes an empty cliche that is equivalent to the contrived Hollywood death scene. It conjures a sterile patient in a sterile bed in a sterile hospital, with sterile nurses speaking softly to teary-eyed family members and a sterile physician looking noble. Occasionally, there is a sterile clergyman silently mumbling a sterile prayer. I believe that, in order for death to be dignified, it must be compatible with the lifestyle of the person undergoing this momentous *life action.* Anything else becomes a mockery and tends to increase latent guilt feelings of participants in this rite of passage. Guilt is not reserved for family members.

Those involved in patient care tend to look upon the dying patient as a personal defeat, and upon death as a blow to professional integrity. Apparently, physicians, nurses, technicians, and the clergy read newspapers and watch television. Perhaps I can best illustrate death with dignity by reminding you of the so-called Symbianese Liberation Army—they died after a shoot-out, in a blazing apartment. Violently. Yet, from their point of view, it was a death with dignity! *They died the way they lived.* I certainly do not suggest using a house as a funeral pyre. But I do urge *acceptance of death as part of life*—especially for the survivors. In a less complicated time the home was the hospice, the family faced death many times and at various stages. Now, for the most part, only the older person dies; and usually in an artificial setting.

In our usual American entrepreneurial tradition, we seem to be heading toward a commercialization of death even before the funeral home is rented. There are pitfalls we must avoid. Perhaps the most dangerous trap is to assume that once hospice care is initiated, the problem is solved; that somehow the person will die out of sight, and the survivors will be magically returned to their usual activities as if nothing had happened. Not so! In order for the hospice concept to work, the basic values of family interaction must be strong enough to avoid purchase of surrogate care and require that significant others participate. But given a dying patient who does not need skilled nursing care, is not bed ridden, is legally competent, whose family-support system needs augmentation for a predictably progressive but lingering illness; how can the system prevent abuse? As long as hospice programs are controlled by dedicated people and are controllably small, and as long as third party payers are not overly involved, we can maintain the notable successes of hospice care. What I fear is the enterprising attorney and imaginative judge who, in concert but without a conspiracy, will open the avenues for the hospice to become a semi-charnel warehouse.

Another serious problem, assuming a solution to the previous difficulty, is personnel. Volunteers, people who have experienced a smooth hospice program, have been a strong and valuable asset in maintaining continuity of most hospices. Even the most dedicated and highly motivated volunteer will reach a limit of availability. The obvious alternative is to develop a new class of "professional helper." But this really defeats the intimacy of the hospice concept. No matter how "professional" this postulated helper may be, how dedicated and expert, there is an endurance limit. A thicker and thicker shell develops, the interactions become encounters and self-survival demands emotional disengagement. No, this alternative is not a recommended one. Time and experience are needed to work this out.

The cost factor is closely related. As a physician, I am more concerned with quality care than cost containment. But as a realistic citizen in a troubled economic era, I am well aware of the fiscal realities of our time. I am also cognizant of the probable fact that as hospices become a matter of law and right, there will be a veritable flooding of all available programs and a demand for more. Our population is aging and the productive work force is decreasing. There is no doubt that an increasing portion of the health care dollar will be channeled in this direction. Perhaps the total system will shift from heavy use of acute facilities to more ambulatory care; perhaps the people of this country will opt for a more healthy (preventive) life style; perhaps defensive medicine will be unnecessary as the courts recognize wholesale abuse of the legal system; perhaps families will become able, and willing, to have

loved ones die at home. Perhaps

As hospices proliferate, and they certainly will, there properly arises the matter of care evaluation. Several models come to mind. An ideal method would be for the participants—givers and receivers of care—to mutually oversee the process. In a sense, this is a variation and extension of the multiple inter-personal relationships that must, of necessity, exist. It is, really, a sophisticated application of the philosophy of free enterprise and a function of the marketplace. But I fear that this will not happen because of the contemporary trend toward regulation. Consequently much time, effort, personnel, and other resources will be expended on building a "system" of directives and an ocean of paper defining the obvious and dehumanizing what should be a sensitive and—in a way—a beautiful experience.

It is curious that our youth-oriented culture has become death focused. In less than 400 years—Virginia Dare was born in 1587—we have reached a stage that Europe did not reach in less than two millennia. In fact, it has only been in the last 50 years or so that we have aged. Not only our population but also our social institutions, our industry, and our thinking have aged. Death, for a long interval, was accepted but ignored in the excitement and frenzy of building the New Jerusalem. But construction is complete and there is no place to go. The ovens of the Holocaust and the clouds over Japan signaled a worldwide crass destruction of life. To top it off, Sputnik forced the realization that Heaven is space, and Hell is on Earth. There is no place to go; death has become obscene; life *must* be continuous. In a significant way, the hospice is a vehicle to return to reality. Most of us will freely concede that all human life must terminate. People die. We resist, strongly, our own, personal death. I do not die. The hospice can demonstrate that each individual must have a clear understanding of his or her own cosmic view: theistic, deistic, agnostic, or atheistic.

If I had to capsulate the ethical and practical concerns of hospice care I would merely refer you to *your* concept of *your* family and its support system. Recall the eskimo's comment to his son: "And this you must do *for* me." Not "to me," but "for me." This statement contains all the ethical and moral imperatives involved. It is based on a clear cut value system based in survival. Each of us must put into practice what our individual, sociocultural situation demands. The hospice, if it is necessary, is merely another tool. It should only be used when other tools are not applicable, and only if it can do the job appropriately, and better. ◀

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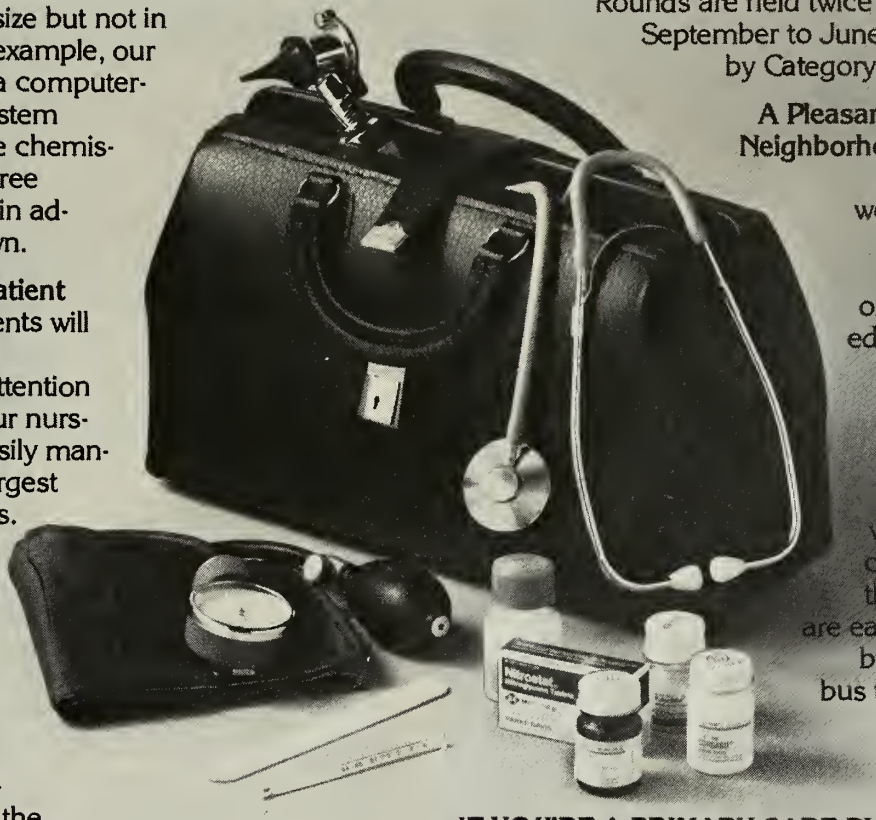
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The Viewbox

Cantributing Editor Terrence Demas, M.D., assaciate professor of radiology,
Department af Radiology, Loyala University Stritch School of Medicine

This month's Viewbox was contributed by Richard E. Marsan, M.D., associate professor of radiology, Loyola University Stritch School of Medicine.

The patient is a 60 year old female who had a cholecystectomy several years before this hospitalization. She now presents with painless jaundice, respiratory failure, and sepsis. The bilirubin is 15.8mg% direct. Alkaline phosphatase is 1760 units, LDH 347 units, SGOT 82 units, SgPT 63 units. Ultrasound demonstrates dilated bile ducts. The pancreas was not successfully visualized. Obstructive jaundice due to stones in the common duct was suspected clinically.

A percutaneous cholangiogram was done and is illustrated in Figure 1.

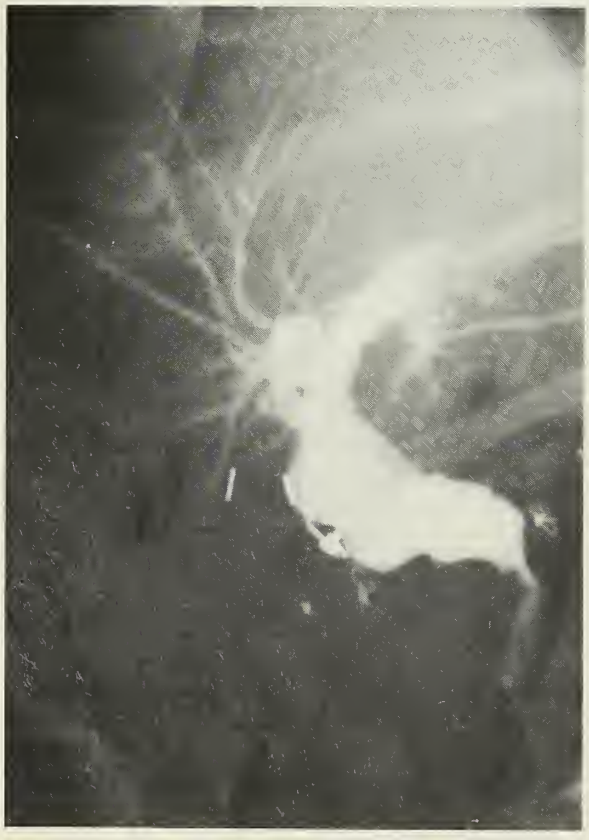


Figure 1

Questions

This patient should be treated by:

1. Pancreaticoduodenal resection
2. Choledochojejunostomy
3. Percutaneous biliary drainage
4. Radiation therapy

(Continued on page 395)

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New Approaches To Breast Reconstruction

By Peter McKinney, M.D., F.A.C.S. And
Bruce L. Cunningham, M.D./Chicago

Requests for reconstruction of the female breast have become more common following extirpative surgery for breast carcinoma. Formerly, breast reconstruction was a multi-staged endeavor, often with less than satisfactory results. Recent understanding of the physiology of musculocutaneous flaps has provided plastic and reconstructive surgeons a reliable technique that allows reconstruction with better results than the earlier multi-staged procedures. By employing the latissimus dorsi myocutaneous flap and a standard silicone prosthesis, more satisfactory breast reconstructions have become possible. Pre-operative planning prior to the extirpative surgical procedure will further improve these results.

Loss or disfigurement of the female breast can induce profound emotional and sexual disruption.[1-3] Fortunately, earlier diagnosis of the disease, recognition of the importance of body image, and improved reconstructive methods have influenced medical opinion as to the advisability and feasibility of restoring the breast. Recent advances in our understanding of the physiology of arterialized musculocutaneous island flaps[4] have considerably shortened the stages of reconstruction and greatly improved results.

Following radical or modified radical mastectomy, the reconstructive surgeon is faced with several problems. The most immediate is a shortage of skin and subcutaneous tissue. An important consideration is that reconstruction of the breast should include restoration of the nipple/areolar complex and the anterior axillary fold.[5] The direction of the original scar also is important. Generally, the transverse incision is preferred, as it lies in the bra line, but it is often carried too far toward the sternum, restricting certain types of clothing.

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BRUCE LANGDON CUNNINGHAM, M.D., is a plastic and reconstructive surgeon affiliated with the University of Minnesota Hospitals, St. Paul-Ramsey Medical Center and Methodist Hospital in Minneapolis.

Timing of Reconstruction

Some centers offer immediate breast reconstruction, but this has limited acceptance. In our opinion, the timing of reconstruction should be based upon the stage of the disease.[6–9]

In our center, patients with Stage I disease wait three to six months before reconstruction. This period allows for a thorough histological examination, and for the scar to soften. An important consideration is that it gives the patient time to come to terms with her loss and develop realistic expectations. A patient who expects reconstructive surgery to restore a normal breast is likely to be disappointed. Reconstruction for patients with Stage II and III disease generally begins six to twelve months following completion of any subsequent therapy.

Reconstruction for patients with Stage IV disease is not entirely contraindicated but must be undertaken with full realization of the likelihood of further difficulty from the tumor. In the event that initial therapy is not curative, recurrence of the disease is most likely at a distant site rather than the chest wall; therefore, reconstruction of the breast does not alter the final outcome of the disease.[10–12]

When anterior chest wall skin coverage is adequate, and if the pectoralis muscle remains intact, and is not fibrotic, subcutaneous or submuscular pockets may be dissected to accommodate silicone mammary prostheses. For some patients this relatively simple operation is sufficient, and volume symmetry is achieved by wearing a brassiere. Nipple and areolar complex can be constructed at the same time or six to eight weeks after implantation of the prosthesis.[13]

The most common problem in reconstruction is contraction, as the scar capsule around the implant may produce a change in the shape of the breast as well as hardening.[5] Where there is radiation-damaged skin, subcutaneous placement of a prosthesis may be too risky. For these patients, use of a flap is recommended.

If skin coverage is inadequate, either from radiation changes or following wide resection, skin and subcutaneous tissue may be added from local flap rotation.[14,15] This gives better padding over the prosthesis and a more natural-appearing breast. In the past these flaps required numerous stages, necessitating multiple hospital admissions. Recent developments in understanding of flap physiology, however, have allowed the plastic surgeon to offer one-stage coverage with skin and subcutaneous tissue. It is now recognized that the skin is in large measure nourished by the blood vessels perforating from the underlying skeletal muscle.[16] Isolating the neurovascular bundle or "leash" has allowed transfer of the entire muscle with appropriate skin in a more reliable manner than skin flaps alone.

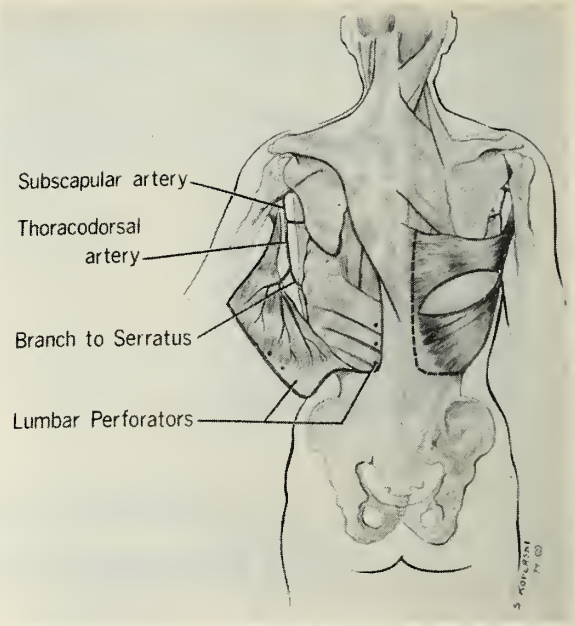


Figure 1
Anatomy of the latissimus dorsi muscle. Note the vascular pedicle (thoracodorsal artery). On the right is simulated the skin island overlying the muscle. *Reproduced by permission of Sandra Koperski*

Anatomy

Incorporating the vascular supply to the latissimus muscle allows transposition of skin and muscle bulk as a myocutaneous unit. This permits the surgeon to reconstruct major deficits in skin and soft tissue of the breast in one stage without a delay procedure.[17,18] The muscle takes its origin from the lower sixth thoracic, the lumbar, and sacral vertebrae and from the iliac crest (Figure 1). This broad, fan-shaped muscle inserts into the intertubercular groove of the humerus. The blood supply from the thoracodorsal artery, a terminal branch of the subscapular artery, enters the deep aspect of the muscle in company with the thoracodorsal nerve. The vessel can reliably be found 10cm from the insertion of the muscle. When possible, it should be preserved during the extirpative surgical procedure. The muscle functions to extend, adduct and medially rotate the arm (Figure 1). In most patients a change in direction of the muscle poses no problem, as by

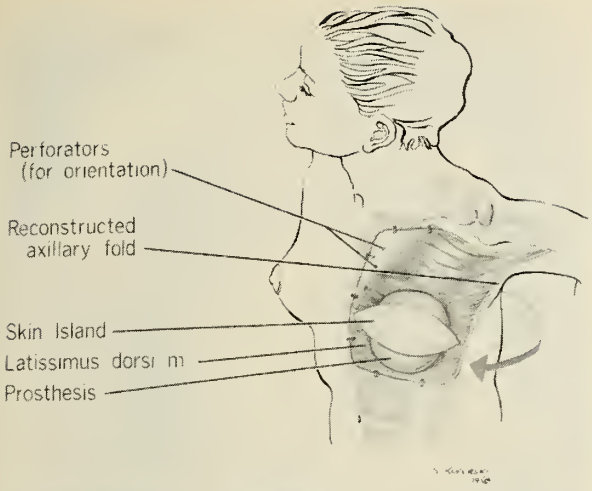


Figure 2
Reconstructed chest wall. Note that the repositioning of the latissimus dorsi muscle creates an anterior axillary fold. The lumbar perforators are now at the superior edge of the flap. *Reproduced by permission of Sandra Koperski*

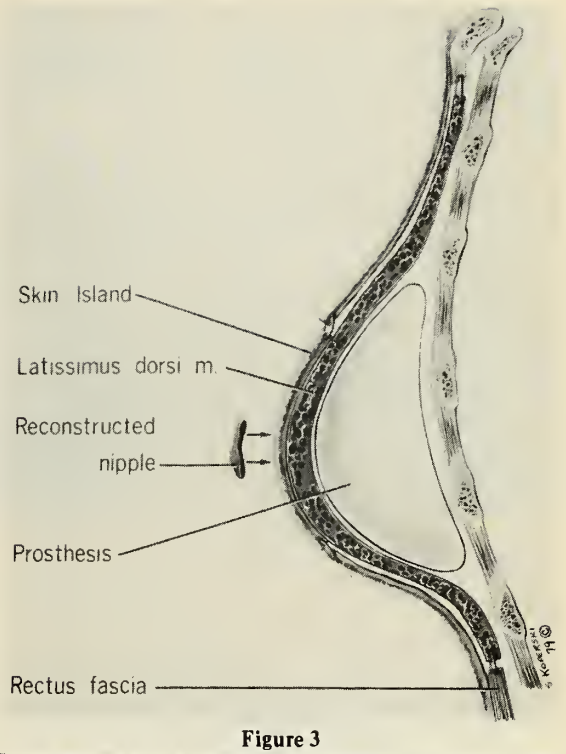


Figure 3
Cross-section of the reconstruction demonstrating the muscle flap and skin island covering the silicone prosthesis. *Reproduced by permission of Sandra Koperski*

preserving the nerve the muscle still functions.

For breast reconstruction, the latissimus dorsi muscle is helpful in three ways. First, if additional skin is required, transfer of a cutaneous island measuring as large as 12x20cm can be created and yet the donor site can still be closed primarily and designed so that most of the scar can be concealed in the line of a brassiere. Second, where adequate skin coverage exists, the muscle alone can be used to provide subcutaneous padding. Third, the edges of the muscle can be used to simulate the anterior axillary fold for those patients who have lost the pectoralis major muscle.

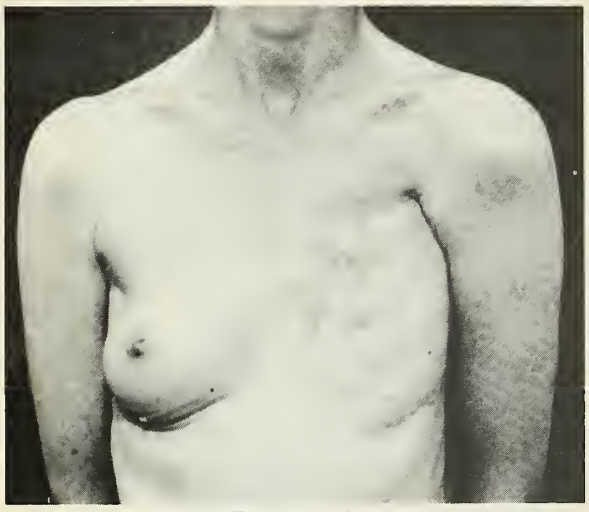
Technique

With the patient in the lateral recumbent position, the vascular pedicle is isolated with the aid of a Doppler probe through an incision that can be incorporated into the creation of the elliptical skin island. Using preoperative markings, the size of the chest wall defect is determined, and an island of skin of appropriate dimension is isolated, retaining its muscular attachment. The latissimus muscle is separated from its origins. This flap of muscle and skin is then tunneled through the axilla to the chest wall and sutured to the midline, sternum and deltoid. The segment of skin fits into the incised breast scar. At the same time, a silicone prosthesis is placed beneath the flap to simulate the breast mount. The cutaneous island, if needed, is designed on the muscle to fit into either a transverse or an oblique mastectomy scar (Figures 2 and 3).

It is possible to reconstruct the nipple and areolar complex at the time of the initial procedure. However, we feel it is advisable to do this at a second stage, because scar contracture from the flap may result in displacement of the nipple (Figures 4 and 5).

Management of the opposite breast depends upon the age of the patient, the family history and the patient's wishes. Subcutaneous mastectomy for the other breast seems to lower the risk of carcinoma, especially in patients with a strong family history of this disease.[19–21] In lower risk patients the opposite breast can be elevated and made smaller if necessary (Figures 4 and 5).

Bostwick's study[22] of 60 reconstructions employing the latissimus dorsi flap reported no flap loss even in patients with radiation and extensive axillary dissections. The flap is so reliable that a breast prosthesis can be placed at the time of initial rotation. Ligation of the thoracodorsal artery has not prevented use of the latissimus flap,



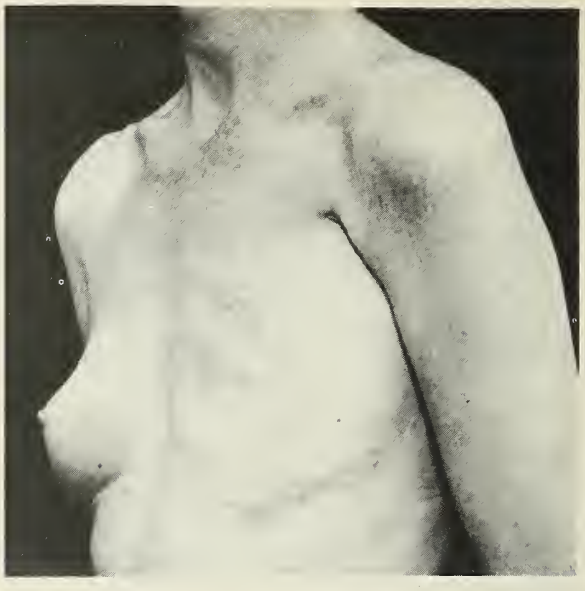


Figure 4, a, b
The patient underwent a radical mastectomy for Stage II disease.

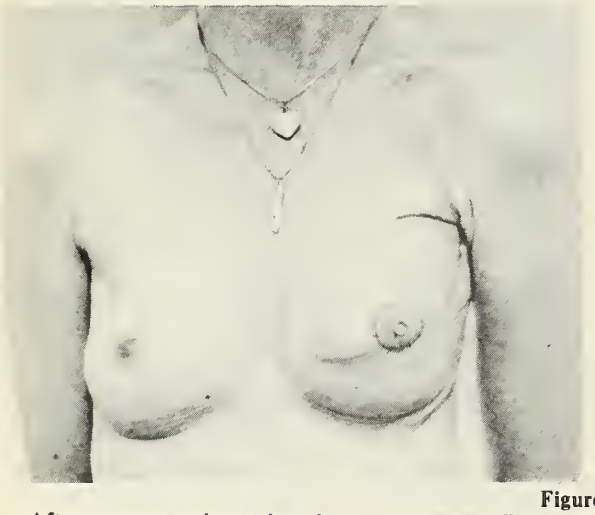




Figure 5, a, b
After reconstruction using the myocutaneous flap, the patient needed no treatment for the contralateral breast.

as it may survive on the collaterals at its insertion, but we make a plea for preservation of this artery whenever this is consistent with good extirpative technique.

Summary

Reconstruction of the female breast following major extirpative surgery has significantly improved. The latissimus dorsi flap provides the plastic surgeon a reliable technique that allows a rapid reconstruction with better results than the earlier multistaged procedures. Preoperative planning prior to the extirpative surgery will further improve these results. ◀

References

A complete list of references for "New Approaches to Breast Reconstruction," may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago 60603.

50 Years Later

The Mechanical Cornpicker

By Nathan Nachlas, M.S. and James D. Schlenker, M.D./Chicago

With the advent of the corn combine, the incidence of cornpicker injuries has declined over the past 20 years. As the result of increased storage costs for shelled corn from the combine, the cornpicker and its associated injuries may again become prevalent. Three patients are presented in order to illustrate injury severity and the poor prognosis despite early aggressive reconstructive procedures. Prevention of these injuries through safety counseling is most important.

The first power takeoff driven cornpicker was marketed in this country in 1929. This machine provided a major agricultural advancement and quickly gained popularity over the ensuing 25 years. Through a series of snapping rollers and belts, the machine serves to snap the ear of corn off the cornstalk, and then proceeds to a dehusking step. It gives as finished product dehusked ears of corn.

Concomitant with this revolution of the corn processing industry was the appearance of a newly described mutilating injury of the upper extremity. First described by Hardin and Robinson in 1950,[1] and later by Maxim, *et al,*[2] Bruner,[3] Melvin,[4] and most recently by Campbell *et al,*[5] injury results when the farmer attempts to free clogged cornstalks from the snapping roller. Once the rollers are freed, the machine responds by suddenly restarting, often entrapping the farmer's fingers, hand, and or forearm (Figure 1). The injury produced is a combination crush, avulsion, and thermal injury.

Treatment of these injuries includes: (1) tetanus prophylaxis; (2) surgical debridement and irrigation of wounds; (3) immediate restoration of vascularity, including fasciotomy and repair of vessels as required and (4) appropriate skin coverage with either skin grafts or flaps.

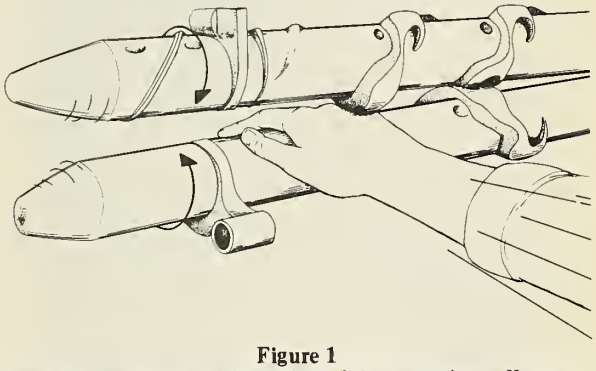


Figure 1
Design and direction of rotation of the snapping rollers are illustrated. The hand is being dragged and crushed between the rollers.

We present three patients with cornpicker injuries to illustrate the severity of injury and poor prognosis despite current methods of treatment.

Patient No. 1

A 57-year-old man suffered a cornpicker injury to the left hand. The skin was avulsed circumferentially over the digits and the little finger was amputated at the proximal interphalangeal joint. The neurovascular bundles of the digits were intact (Figure 2).

After initial debridement, the fingers and the thumb were buried in a subcutaneous pocket in the abdomen (Figure 3). Three "delay" procedures were performed in order to release the hand from the abdomen. With each "delay," the

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Figure 2
Patient No. 1: Avulsion of skin from the thumb and fingers with partial amputation of the little finger. The neurovascular bundles are intact.



Figure 3
Patient No. 1: Degloved portions of the fingers were buried in a subcutaneous pocket in the abdomen.

incisions were extended further around the digits. Each procedure was separated by ten days and the hand was released from the abdomen six weeks after injury. Full thickness abdominal skin was preserved on the dorsum of the thumb and fingers. Fatty tissue from the abdomen which was adherent to the palmer aspect of the digits was trimmed and covered with split thickness skin grafts. These skin grafts took completely and he was started on vigorous physical therapy (Figure 4). Two months later, a remaining syndactyly between the index and middle fingers was released. He has regained partial use of his left



Figure 4
Patient No. 1: Two weeks after application of split thickness skin grafts to the palmar aspect of the fingers. Full thickness abdominal skin covers the dorsum of these fingers.

hand. The metacarpophalangeal joints have full motion but the interphalangeal joints have very limited motion.

This man was able to extricate his hand from the cornpicker before the hand and forearm had been dragged between the rollers. Implanting the hand in adipose tissue immediately beneath the skin of the abdomen was an easy, rapid and secure method of preserving exposed tendons and other soft tissues. The adipose tissue surrounding the denuded digits as well as the abdominal skin over the dorsum of the digits became adherent to and progressively more dependent upon vascular supply from the digits after each "delay" procedure.[6-9] After releasing the hand from the abdomen, the full thickness abdominal skin provided durable coverage over the dorsum of the digits. The split thickness skin grafts which were applied to the adipose tissue over the palmar aspect provided a good tactile surface for the digits.

Patient No. 2

This 28-year-old man suffered a cornpicker injury to the right forearm. The result was avulsion of skin and muscle over the anterior surface of the proximal forearm and a crushing thermal injury by the roller, which was in contact with the



Figure 5
Patient No. 2: Avulsion of skin and muscle over the anterior surface of the forearm with interruption of the ulnar and radial arteries.

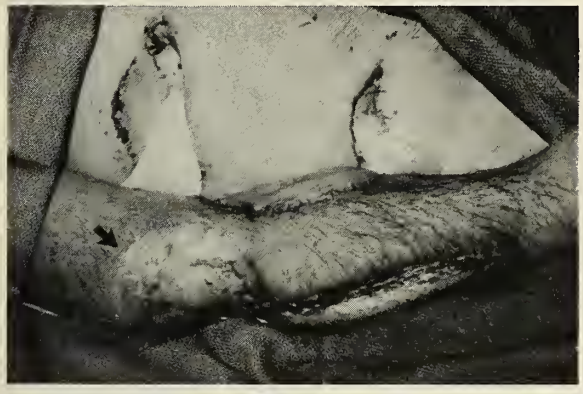


Figure 6
Patient No. 2: Anterior defect on the arm is covered with a transverse abdominal flap. The defect over the dorsum of the forearm has been successfully covered with a split thickness skin graft (arrow).

dorsal surface of the arm (Figure 5). The hand was noted to be severely ischemic on initial examination.

At surgery, he was found to have interruption of the radial and ulnar arteries and the median and radial nerves in the proximal forearm. After debridement, the radial and ulnar arteries were repaired with vein grafts taken from the cephalic vein distally in the same arm. The necrotic skin over the dorsum of this arm was debrided and the entire exposed area was covered with split thickness skin grafts. The damaged nerves were not repaired.

The skin graft took well over the dorsum of the arm but poorly over the anterior aspect because of muscle necrosis and infection with *Pseudomonas aeruginosa*. Despite treatment with appropriate antibiotics, rupture of the repaired ulnar artery occurred which required ligation. The radial artery remained patent. Three weeks after injury, the anterior defect was covered with an abdominal flap (Figure 6). Two weeks after initial placement of the abdominal flap, the flap required revision and advancement of its inset.



Figure 7
Patient No. 3: The defects on the opposite sides of the forearm have been covered with superiorly and inferiorly based abdominal flaps.

The flap was divided four weeks later.

Although the arm has been salvaged, there is considerable functional loss as a result of injury to the muscles and the radial and median nerves. Additional procedures including nerve grafting and tendon transfers will be required to restore function to this extremity.

The patient demonstrates the difficulty in estimating the extent of the initial injury. As a result of progressive tissue necrosis and infection, coverage of the defect initially with split thickness skin grafts and later with an abdominal flap was associated with complications. The rollers produced avulsion and crushing of tissue on the anterior surface and crushing and thermal injury on the dorsal surface. The exposure of opposing surfaces of the forearm to several modalities of tissue destruction (crush, avulsion and thermal injury) made the initial treatment particularly difficult. The infection was a result of heavy contamination at the time of injury combined with the presence of necrotic tissue.

Patient No. 3

This 45-year-old man suffered a cornpicker injury to his right forearm. After initial debridement the ulnar artery was repaired with a vein graft. The defect on the dorsal surface of the forearm was covered with a thoracoepigastric flap and that on the volar surface of the forearm was covered with an inferiorly based abdominal flap (Figure 7). Five days later, an additional debridement of necrotic tissue was necessary. Despite the initial successful revascularization of the hand, necrosis occurred. Two weeks after the injury, an amputation at the level of the wrist was necessary. Eventually, four months after the original injury, an amputation through the proximal

third of the forearm was necessary. He is being rehabilitated with an upper extremity prosthesis.

This patient demonstrates the frequent need for an amputation after this type of injury despite heroic efforts at revascularization of the hand and flap coverage.

General Discussion

We are now in the 50th anniversary of the introduction of power takeoff driven mechanical cornpickers. Following the peak of related injuries in the mid-1950's, there has been a progressive decline over the past 20 years. In fact, agricultural accidents related to cornpicking declined from 300 per year in Illinois in the 1950's to less than 20 per year in the late 1960's.

The decline in cornpicker injuries has been attributed to three factors.[10] First, the nature of the corn plant itself has changed from a 16 foot towering structure, very difficult to mechanically harvest, to a smaller, more easily harvested plant. Second, safety counseling has become more widespread over the past 25 years, largely as a result of efforts of Extension Safety Specialists who now conduct 75-85% of such safety teaching in Illinois. An aggressive approach has been utilized to reach 25 counties to discuss the potential hazards of the corn harvesting process. Third, the popularity of the cornpicker has decreased since the 1950's following the advent of the corn combine. This machine differs from the cornpicker in that it shells the corn, which is then stored in a bin. The corn combine has the advantages of decreasing production costs of corn grain as well as sharply decreasing the number of related injuries. The combine is a more powerful machine than the older cornpickers and less often becomes plugged.

One would hope that with the advent of the corn combine, injuries such as those described above would soon become obsolete. In fact, last year there were approximately 100,000 corn combines in the state, representing 95% of corn harvesting machinery. However, the shelled corn from the combine requires an environment with less than 15% humidity because of its inability to tolerate moisture as well as the eared corn produced from the cornpicker machinery tolerates humidity. Over the past four years, farmers have found that the rising storage costs of the combine produced shell corn offset the initial savings. As a result, the cornpicker has become relatively more economical. We may expect to see a larger number of cornpicker injuries if this equipment returns to the field.

On the basis of our experience, the severity of cornpicker injuries with the triad of crush, avulsion and thermal damage makes the initial assessment of tissue damage difficult and renders functional reconstruction a surgical dilemma. In a recently published series from the Mayo Clinic, despite medical care within four hours of injury in 96% of patients, over half of these patients developed wound infections irrespective of antibiotics.[5] Furthermore, while only 4% of the patients suffered amputation of the entire hand at the time of injury, with 32% suffering single or multiple digit loss or mid-palmar amputation, these statistics increased to 25% and 45% respectively on follow-up, with an additional 7% requiring mid-forearm amputation.

Emphasis in treatment of cornpicker injuries must remain with their prevention. The typical setting for these injuries is the wearied farmer, approaching the end of the work day, when damp husks have an increased probability of plugging the machine and the farmer has an inclination to free the machine without ensuring the proper safety precautions. With the probability that the mechanical cornpicker will again rise in popularity, the necessity of safety prevention teaching cannot be overemphasized. ◀

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We would like to extend our appreciation to Mr. Ordie Hogsett, Extension Safety Specialist at the College of Agriculture, University of Illinois, Urbana-Champaign, and Mr. Wallace McDougall, Manager of Product Safety at AVCO, for their help in preparing this manuscript.

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Violence: The Ugly Face Of Amphetamine Abuse

By V. SIOMOPOULOS, M.D./CHICAGO

The amphetamines are synthetics with central and peripheral sympathomimetic actions. Their central effects include euphoria, psychomotor excitation, insomnia, anorexia and, in sensitive individuals, after chronic oral or intravenous use or a single large dose, suspiciousness, irritability, aggressiveness, stereotyped behavior and misinterpretations of reality with or without delusional ideas and hallucinations.[1-3] Independent of the development of psychotic symptomatology, abuse of amphetamines may lead to aggressive and antisocial behavior,[3-6] a fact that became apparent in this country in the late 1960s when amphetamine abuse reached almost epidemic proportions.[4] Today, although there is no evidence of epidemic amphetamine abuse in this country, amphetamines and amphetamine-like substances are, according to informal statistics, used extensively by young polydrug abusers in large metropolitan areas. In view of the fact that small, but substantial, amounts of these substances are provided through prescriptions of weight reducing compounds, the author of this paper believes that the general physician should be alerted once again to the inherent dangers in use of these drugs.

During the years 1974-1976, working at the Forensic Unit of the Illinois State Psychiatric Institute, this author evaluated psychiatrically a large number of individuals who were found by the Cook County Criminal Court unfit to stand trial on various felony charges. Most of these individuals gave history of extensive drug abuse. Generally, they would use any euphoria-inducing substance (narcotics, marijuana, barbiturates, LSD, amphetamines, cocaine, phencyclidine) although many expressed preference for certain of these substances.

The vast majority of these individuals refused to discuss the charges against them, and valid information concerning the relationship between drug abuse and the alleged crimes could not be obtained. Yet, a significant number of these patients not only admitted the charges against them, but also gave history of substance abuse during the 24 hours preceding perpetration of the crime. The psychiatric diagnosis in most of these cases was schizophrenia and antisocial personality, while the drugs involved most frequently were amphetamine and amphetamine-like substances.

The following vignettes represent a characteristic sample of cases in which such a direct relationship between amphetamine abuse and criminal behavior was found.

Report of Cases

Case One—A 27-year-old single black man was admitted for evaluation of his need for mental treatment after he was found unfit to stand trial on a charge of unlawful use of a weapon. He had long-standing history of drug abuse, but no prior psychiatric hospitalizations. He had begun exclusive use of amphetamines about six months before his arrest. About a week prior to the incident that led to his arrest, he began injecting intravenously large amounts of phenmetrazine (up to 1,500mg. daily) and methylphenidate (up to 300mg. daily). A few days later he developed the delusional idea that he was followed in the streets of the city by strangers. In the evening before his arrest, believing that he was going to be assassinated, he resorted to an abandoned house in order to escape from his "persecutors". Subsequently, using rags and gasoline, he made small balls of inflammable mass, (Molotov cocktails) a weapon he was planning to use against his "persecutors" as soon as they would enter the house. He remained alert throughout the night waiting for his "enemies." The next day he came out of the house carrying the original weapon in a plastic bag, but his suspicious behavior attracted the attention of the guards of a nearby factory, who placed him under arrest.

Case Two—A 26-year-old single white man was arrested on the charge of attempted murder and, after he was found unfit to stand trial, was referred to the Illinois State Psychiatric Institute for an evaluation of his need for mental treatment. He denied any prior psychiatric treatment, but he admitted use of a variety of illicit drugs (marijuana, LSD, amphetamines, cocaine) since the age of 20. For several months before his arrest he was using exclusively amphetamines (60-90mg. daily) orally. Then gradually he became irritable,

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quarrelsome, suspicious. Suspecting some sort of "conspiracy" against him by his co-workers, he bought and brought with him a sharp instrument for self-defense in case of an attack by the "conspirators." Believing that he was followed, he would go to work by a different route each time. About a week before the arrest incident he bought a gun for more effective self-defense. During this week, in order to alleviate his mounting anxiety, he increased the number of amphetamine tablets he was taking daily. On the day of his arrest, while he was in the car of a co-worker, he was seized by the idea that the men in the group were going to assassinate him and acting upon this belief, he took out his gun and started shooting at them

Case Three—A 20-year-old single white man with a history of amphetamine abuse since early adolescence was arrested on the charge of unlawful use of weapon. He had been arrested three times in the past for burglarizing drug stores in search of amphetamines. There was no history of prior psychiatric treatment. About two weeks before the arrest incident he was dismissed from his job as a file clerk, because he became involved in a physical fight with a co-worker. Looking for a job he went to a nearby convent, where he had worked in the past, but he was turned down immediately, apparently because of his rude behavior. To alleviate feelings of sadness and humiliation generated by this incident, he took an undetermined number of tablets one after the other upon returning home. A few hours later he began experiencing auditory hallucinations—"voices" in a foreign language, the sound of a siren. Then, excited, irritable, unable to sleep, he became preoccupied with feelings of vengeance against the nuns. Around 3:00a.m. he returned to the convent carrying a shotgun. At first, he shot at the lights of the door, but he failed, then he shot repeatedly at the door. Apparently, he was unable to break-in and shortly after was arrested by the police, while outside the convent.

Case Four—This is the case of a 43-year-old white married man accused of murder. He had history of alcoholism and drug abuse and had spent three years in the state penitentiary for molesting a minor. The crime was committed after excessive drinking and subsequent intake of undetermined number of amphetamine tablets. Returning home by bus he shot and killed another passenger, whom he did not know, believing momentarily that the latter, as he moved his hand into the inside pocket of his coat, was going to draw a gun and kill him. There was no history of prior psychiatric treatment.

Case Five—A 24-year-old single white man, hospitalized in the past twice with the diagnosis of paranoid schizophrenia, was found unfit to stand trial on the charge of murder. An amateur printer and photographer, he had used a variety of psychedelic drugs believing that these substances would enhance his sensibility and improve the quality of his art. For several weeks before the arrest incident he was preoccupied with the delusional belief that "certain" individuals motivated by jealousy of his success as an artist, were organizing a "conspiracy" against him. He suddenly "realized" that the deaths in the past year of two close relatives and two friends of his were not a mere coincidence, but part of an organized "plot" against him and his family, and reached the conclusion that the "conspirators" were preparing his own assassination. On the day of the arrest incident, after taking six amphetamine tablets, he went to a friend's party. There, upon seeing an individual carrying a pan full of boiling water, the idea came to him that this person belonged to the group of "conspirators" and was going to pour the boiling water on his head. Therefore, using a gun he carried for self-defense, he killed the man.

Case Six—A 20-year-old single white man with history of amphetamine abuse since age 14 was arrested for attempted murder. He had been using the drug orally, five to six tablets of undetermined strength daily. He reported that after continuous use of the drug for several weeks he would become irritable, suspicious and prone to become involved in fights with others. Abstaining from its use for several weeks, he would feel depressed, emotionally empty, and often think of suicide. The victim of the crime for which he was arrested was his own mother. Upon seeing him taking the drug, she attempted to advise him against its use but this infuriated the patient, who grabbed a fork and attacked her with it inflicting serious wounds on her face and other parts of her body.

There was no history of prior psychiatric treatment or prior arrests.

Case Seven—This is the case of a 22-year-old single white man who began using methamphetamine and barbiturates about 5 years prior to his most recent arrest for burglary of a drug store. He had been arrested twice before on similar charges. There was no history of prior psychiatric treatment. His pattern of amphetamine intake consisted of intravenous injections of methamphetamine three to four times daily for several days, followed by a two to three day interval of rest. He

was using for that purpose usually 30 tablets of 15 mg. strength which he was dissolving into boiling water. Subsequently, he would inject the solution after removal of the coating with a piece of cotton. He reported that shortly before his arrest, he used to stay up all night taking his radio apart and putting it back together repeatedly. There was no evidence of delusional or hallucinatory experiences.

Case Eight—A 31-year-old single white man with a history of three previous arrests and convictions for burglary was arrested once again for burglary of a drug store. A former heroin user, he had begun to use amphetamines about three months before his arrest. The burglary was attempted in search of amphetamines, the last supplies of which he had used a few hours before the incident. His drug intake pattern consisted primarily in intravenous injection of phenmetrazine. He described his mental state after intake of the drug as follows: "It gives me self-confidence . . . I think fast, I talk fast . . . it increases my sexual drive . . . I can have sex with three or four girls one after the other on the same night. I feel the whole world is mine." There was no evidence of delusions or hallucinations.

Discussion

In each case described above the use of amphetamines was associated with emotional lability, euphoria and irritability. Misinterpretations of reality and delusional ideas in the absence of preexistent schizophrenic illness were present in three cases (cases one, two, four). Hallucinations, specifically auditory hallucinations, were described only by one patient (case three) after he consumed large amounts of phenmetrazine orally. Stereotyped behavior was noted in the history of one case (case seven) in which, however, psychotic symptoms were absent. History of hypersexuality was given in only one case (case eight). In at least one case (case six) the patient most likely resorted to the use of amphetamines in order to relieve overt depressive symptomatology.

Methylphenidate, an amphetamine derivative that was originally thought to have only anorexic properties, was associated with delusions of persecution after intravenous use for several days in one case (case one) and auditory hallucinations after a single large oral dose in another case (case three). Cases seven and eight represent examples in which psychological dependence on the drug led indirectly to minor violations of the law.

Concerning the relationship between amphetamine abuse and criminal behavior, most investigators agree that amphetamines cause emotional lability, suspiciousness and impulsivity which could lead to aggressive and antisocial behavior. It is not uncommon for the amphetamine abuser to carry weapons of all kinds for "self-protection" and "self-defense" against his many "enemies" as illustrated by the first five cases. In the case of the schizophrenic patient who abuses amphetamines, the drug would probably further impair the patient's poor contact with reality and weak ego controls and increase the likelihood of violent behavior. This is illustrated by case five. Although the drug was not apparently responsible for the delusions of this patient, the crime probably would not have occurred if the patient had not used amphetamines.

The "criminogenic" effect of amphetamines has been attributed by Grinspoon and Hedblom[6] to the properties of these drugs to (1) focus attention on immediate stimuli, a property which tends to make the individual react in a reflex-like manner; (2) cause psychomotor stimulation which tends to lead to immediate action and (3) increase the tendency of the individual to assume a "personal orientation" in life, frequently misinterpretating actions of others as directed against him. From the pharmacological point of view, the psychomotor excitation, affective arousal and paranoid symptomatology of amphetamine abuse have been attributed to release of norepinephrine and dopamine in functionally important receptor sites in the central nervous system.[8]

Independent of the possible causes of the "criminogenic" effects of amphetamines, the cases reported above show once again that amphetamine abuse may easily set up conditions in which criminal behavior is likely to occur. ◀

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Case Reports

Associated with IUD Insertion

Spontaneous Early Rupture Of A Pregnant Uterus

By PEDRO A. POMA, M.D. AND CHRISTOS REKKAS, M.D./CHICAGO

Uterine rupture is rare but fraught with severe complications. Awareness of spontaneous uterine rupture may assist in decreasing the high complication rate. Uterine rupture is commonly associated with a previous breach in the uterine wall. Cesarean sections, hysterotomies, uterine manipulation and curettage are procedures which may affect the integrity of the uterine wall.

A case of spontaneous uterine rupture at 15th week of pregnancy in a patient who had difficulties with an intrauterine device (IUD) is described. The purpose of this report is to underline another predisposing factor to uterine rupture.

Uterine rupture is a relatively rare but frightful experience associated with high mortality, especially when the diagnosis and treatment are delayed. Most uterine ruptures occur toward the end of pregnancy. These ruptures are commonly associated with labor in patients with previous uterine scars (such as those from cesarean sections, hysterotomies, myomectomies, and cornual resections), and with the improper use of oxytocics, with operative vaginal deliveries, unrecognized maternal and fetal anomalies and inadequate labor management.[1]

Uterine rupture before the onset of labor is more rare, and more commonly overlooked. Obvious causes of uterine rupture include blunt or penetrating trauma, the first usually more difficult to diagnose because it is associated with an asymptomatic interval.[2] Predisposing factors for uterine rupture include adenomyosis, uterine congenital anomalies, degenerating myomas, cornual pregnancies, uterine wall invasion by trophoblastic tissue, severe uterine infection, history of vigorous currettage and deep cervical lacerations.[3]

There are also several cases described in the literature of uterine rupture during the second trimester of pregnancy. In these cases, rupture was associated with the use of oxytocics in patients with or without uterine scars.[4,5] It is easy to assume that all previously mentioned causes may contribute to uterine rupture at any stage of pregnancy.

The following report describes the case of a patient with spontaneous uterine rupture at the 15th week of pregnancy. The patient had previously used an IUD.



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Report of a Case

A 25-year-old woman, Para 1001 was admitted with a diagnosis of Hypermesis Gravidarum. Her last menstruation had begun on September 1, 1974. She complained of vomiting accompanied by abdominal cramps, and the passage of loose stools had ensued three hours before admission. She appeared pale. Her weight was 99.8Kg; her blood pressure 180/100mmHg; her pulse 100/minute. There was abdominal guarding, and a "vague" infraumbilical palpable mass was described. The bowel sounds were present. Her hemoglobin was 10.4gm, hematocrit 32%, Group O Rh positive.

Seven hours later, the diagnosis

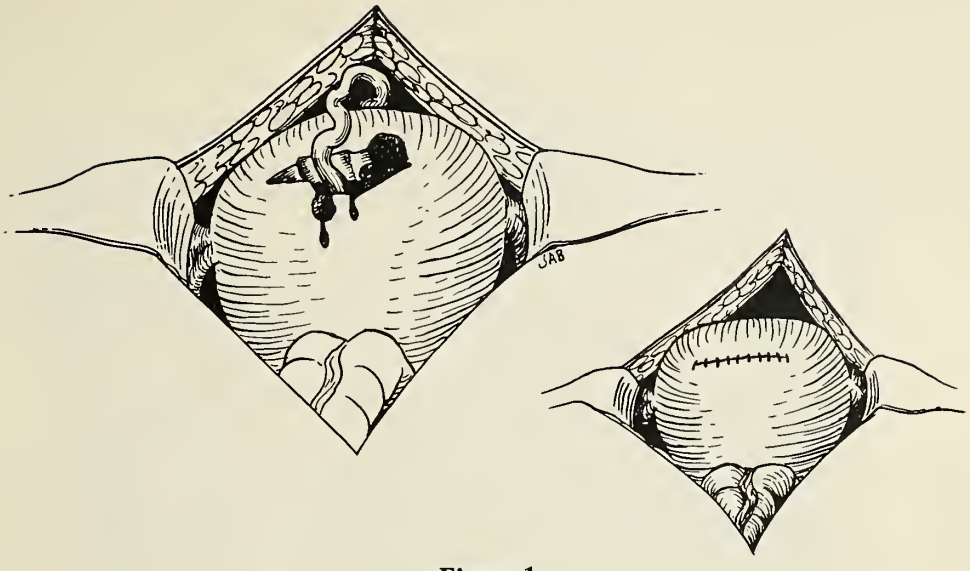


Figure 1

of acute abdomen was considered. Gynecological consultation was sought 15-hours later. Then, blood pressure was 106/70mmHg and pulse 124/minute. The abdominal mass was noted at 5cm above the umbilicus. The cervix was closed and there was no evidence of bleeding or bulging of the cul-de-sac.

A blood transfusion was begun following the diagnosis of hemoperitoneum. Hemoglobin was 8.5gm and hematocrit 24% before laparotomy. Through an infraumbilical vertical incision the hemoperitoneum was confirmed. The uterus showed a fundal rent, and a normal appearing, 17.5cm female fetus was found free in the abdominal cavity; her weight was 96gm. The fetus was attached by an 18cm umbilical cord to the placenta (still in the intrauterine cavity implanted in the posterior wall) through the fundal laceration (Figure 1). After the placenta was removed, the ragged edges of the 5cm fundal laceration were excised and closed with two layers of continuous and one of interrupted size "0" chromic catgut.

The patient was given five units of compatible pack-cells. On histologic examination the uterine wall edges were found to be unremarkable; placenta was bloodless with some hydropic villi at histological study.

Review of records showed that in 1970, this patient delivered a male infant 3120gm. Her pregnancy was complicated by excessive weight gain and arterial hypertension. She had a spontaneous vaginal delivery, without evidence of lacerations; the uterine cavity was not explored. The postpartum course and check-up were unremarkable. She returned to have a Lippes Loop D inserted, which had to be removed 2 months later because of pain and bleeding since insertion. She took oral contraceptives for the following 18 months and then they were discontinued due to arterial hypertension. In June, 1973, a Dalkon shield was inserted; she tolerated it for the following 12 months despite the pain and bleeding. After this device was removed she discontinued contraception. She had no previous history of curettage, other pelvic surgery or infection.

This patient was discharged on the seventh postoperative day and her follow-up was uneventful. During 1978 she became pregnant again and delivered vaginally without complication, except arterial hypertension.

Discussion

Uterine rupture during pregnancy is presently rare, but incidence is likely to increase in conjunction with incidence of cesarean section and hysterotomy. Uterine rupture, which occurs during labor or abortion, usually occurs at the lower uterine segment. The rupture before labor and earlier in pregnancy almost always occurs at the corpus.[3] Bleeding of the lower uterine segment rupture may be evident through the vagina, although the parametrium commonly becomes infiltrated. Bleeding of the upper segment rupture is intra-abdominal bleeding. Thus, uterine rupture during the first half of pregnancy is commonly considered a "rupture ectopic pregnancy."

A fast pulse is an important and reliable sign of uterine rupture. The diagnosis should always be considered in the presence of a fast pulse, even with a normal hemoglobin value, because this value falls slowly and may be deceiving.

Felmus and coworkers[3] reviewed the literature (1850-1953) and summarized 116 cases, adding five new cases of spontaneous uterine rupture of an intact uterus before the

onset of labor. Twenty-three percent of their 121 cases had had previous uterine manipulation (curettage which removed considerable amount of myometrial tissue or manual removal of the placenta). In 28% of their cases, the rupture occurred before six months' gestation.

Our search of the literature failed to find additional cases of spontaneous rupture of a pregnant uterus before the onset of labor without the association of well-known etiological and predisposing factors. There were some exceptions such as the case of spontaneous rupture at the twentieth week,[6] and another at 24th week with a dead fetus retention for 2.5 years.[7]

After a review of the multiple outpatient and inpatient records in our case, none of the reported etiological and predisposing factors could be identified. The only information of etiological importance is that related to secondary effects related to this patient's IUD insertion. Pain and bleeding finally required IUD removal.

Another Case

Bateman[8] presented a patient with spontaneous uterine fundal rupture at the 22nd week of a twin gestation. His patient had an antecedent of uterine perforation during a curettage for incomplete abortion. She also had the history of a possible mole. The incidence of uterine perforation during curettage varies according to the physician's experience. The incidence is higher with less experience, and the occurrence of perforation may not even be recognized. Many uterine perforations probably go unreported. The incidence of perforation in elective abortion cases varies from 0.04% to 1.5%.[9] The uterine sound is commonly the perforating instrument.[9] It is worth noting that Nathanson, in order to decrease the incidence of uterine perforation during termination of pregnancies, does not accept patients with uterine scars or with histories of three or more curettages for any reasons.[9] He also emphasizes the increased risk of perforation associated with close-space pregnancies.

The incidence of uterine perforation during IUD insertion (whether this occurs while probing the uterus with a sound, with the IUD applicator or with the IUD itself) is also difficult to determine precisely. This is a one-person procedure, almost impossible to check and difficult to teach, unless severe complications develop. The acceptance of the fact that uterine perforations indeed occur during IUD insertion helps to explain the presence of extrauterine IUDs, rather than merely accepting the theory of the "wandering loop" working its way throughout the uterine wall. Uterine perforation during insertion is painless. Some patients may remain asymptomatic for prolonged periods, as occurred to the patient described by Saronwala and coworkers.[10] This patient had an IUD removed by suprapubic cystotomy seven years after its insertion. Extrauterine devices should be removed as soon after diagnosis as is possible.

Uterine perforations can be either incomplete or complete (perforation though the entire thickness of the uterine wall). Pain and bleeding are commonly expected after this complication. Recently, laparoscopictrocar and electrocautery uterine fundal injury have been associated with spontaneous rupture of a primigravid uterus during the third trimester[11] affirming the etiological importance of myometrial wall injury.

When uterine rupture occurs, the retraction of uterine musculature after extrusion of its contents often prevents total exsanguination. Fundal rupture is somewhat removed from the main blood supply, which allows less bleeding than in cases of cornual pregnancy.

Due to our patient's age and parity, the uterine laceration was sutured. She has since successfully delivered vaginally. Suture of uterine laceration should be considered: (a) when the patient's condition is poor; (b) when suturing is technically feasible; (c) when there is no infection or extensive necrosis and (d) when the patient is young and desires more children. In subsequent pregnancies, these patients should have elective cesarean sections soon after fetal maturity is evident.[12]

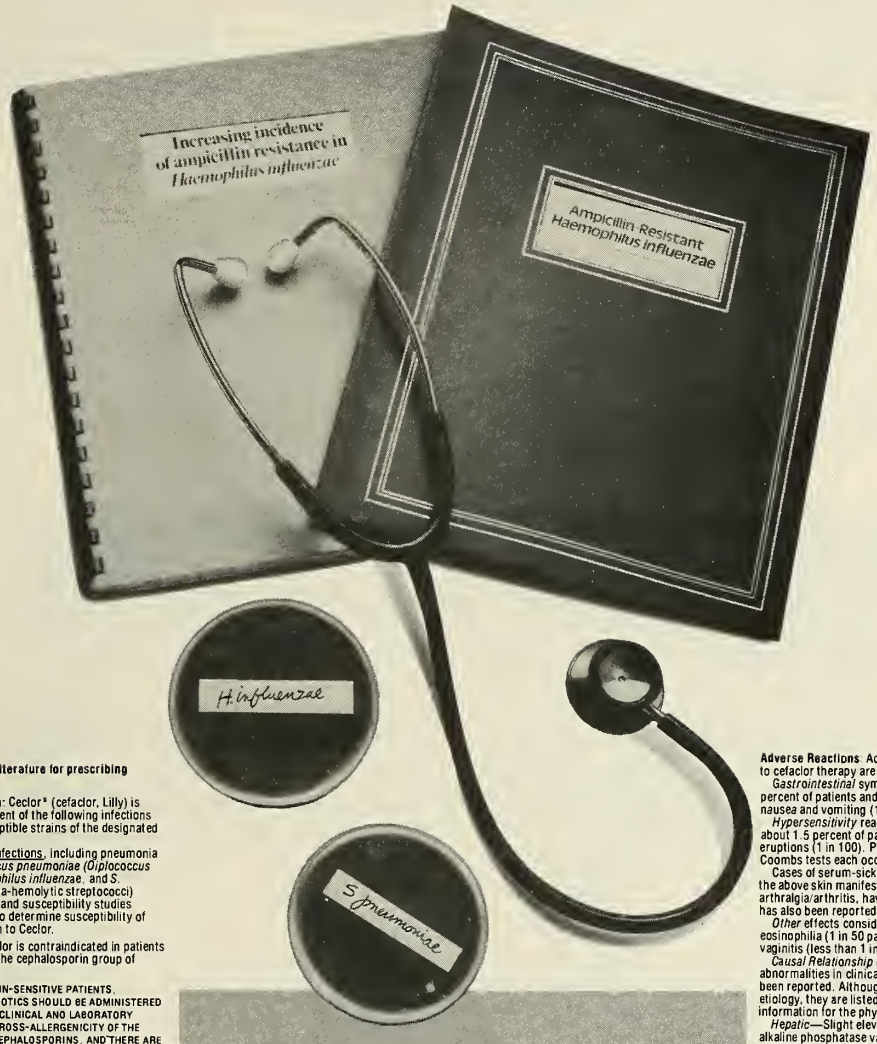
Uterine perforations occur more often than is reported. Cases similar to that described here are apt to occur even more frequently as incidence of curettage and IUD use increase.

Spontaneous uterine rupture during pregnancy must be also considered in patients who have symptoms compatible with abortion or hemoperitoneum and also in those who have histories of intrauterine manipulation, including IUD insertions. ◀

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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

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Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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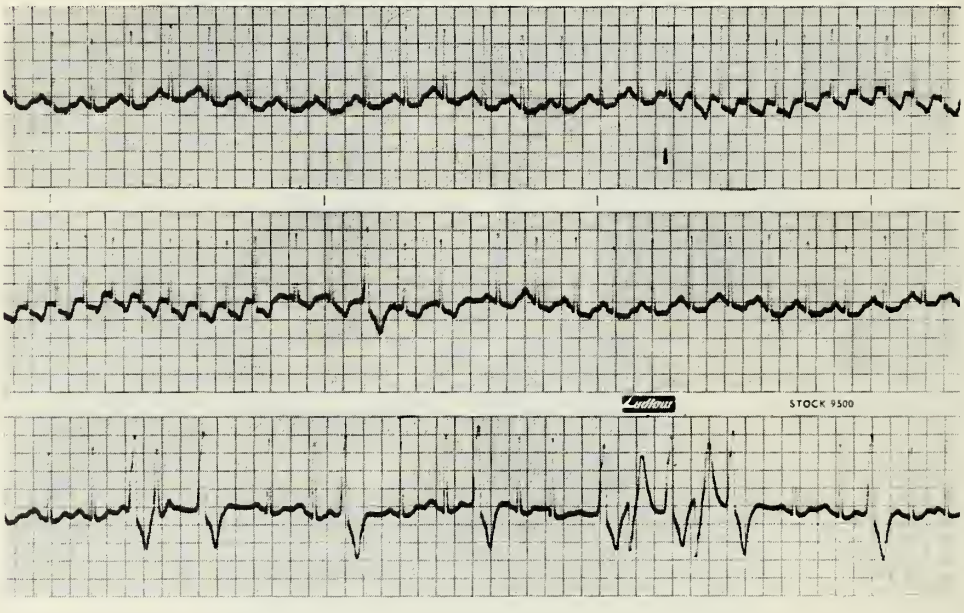
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100061

EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hole, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Ralf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a sixty-three year old man who complained of an intermittent, irregular heart beat. He had taken some propranolol in low doses and found that it worsened his palpitations. There were no associated symptoms. His physical examination demonstrated a mid-systolic click and a late systolic murmur. An echocardiogram demonstrated a mitral valve prolapse. A multistage exercise ECG test was ordered. The ECG strip shown is from the end of exercise to the early recovery period.



Questions:

1. **The ECG shows:**
 a. Accelerated idioventricular rhythm.
 b. Cycle dependent bundle branch block.
 c. Paroxysmal supraventricular tachycardia.
 d. Frequent premature ventricular beats, a couplet of ventricular beats and a short run of multifocal ventricular tachycardia.
 e. Exercise induced ST segment depression.
2. **The following statement(s) is/are true:**
 a. This valvular abnormality is alleged to result from fibromyxomatous degeneration of the mitral valve.
 b. Mitral valve prolapse has been associated with atrial septal defects, rheumatic heart disease, coronary artery disease, idiopathic hypertrophic subaortic stenosis, as well as skeletal deformities.
 c. Mitral valve prolapse has been described in over 20% of healthy females with the use of the echocardiogram.
 d. Sudden death has been described in 1.4% of patients with mitral valve prolapse and arrhythmias.
 e. All of the above.

(Continued on page 406)

OBITUARIES

****Blumklotz, Bruno,** Chicago, died March 29, 1981 at the age of 82. He was a 1924 graduate of the Friedrick-Wilhelmes University Medical School, Berlin, Prussia.

***Boysen, Raymond Theodore,** Rock Island, died April 27, 1981 at the age of 74. He was a 1936 graduate of the Chicago Medical School.

***Chechile, Dominic T.,** Chicago, died April 30, 1981 at the age of 70. He was a 1939 graduate of the Loyola University Stritch School of Medicine.

****Cottle, Maurice,** Chicago, died May 5, 1981 at the age of 85. He was a 1929 graduate of the University of Illinois Medical School.

***Danilevicius, Zenonas,** Chicago, died April 15, 1981 at the age of 66. He was a 1938 graduate of the Kaunas Medical Institute, Kaunas, Lithuania.

***Fisk, Kenneth,** New Mexico, formerly of Bensenville, died January 16, 1981 at the age of 78. He was a 1932 graduate of the Chicago Medical School.

****Helwig, Alvin,** Tinley Park, died April 29, 1981. He was a 1906 graduate of the University of Illinois.

***Hempel, Warren V.,** Alton, died April 18, 1981 at the age of 70. He was a 1943 graduate of the St. Louis University School of Medicine.

***Karwoski, Agnes L.,** Chicago, died March 6, 1981 at the age of 66. Dr. Karwoski was a 1939 graduate of the Loyola University Stritch School of Medicine.

****Kearney, James Francis,** Chicago, died April 14, 1981 at the age of 78. He was a 1929 graduate of the Loyola University Stritch School of Medicine.

***Kelly, Frank B.,** Chicago, died April 18, 1981, at the age of 88. He was a 1921 graduate of Rush Medical School.

***Patt, John Edward,** Chicago, died March 27, 1981, at the age of 72. He was a 1937 graduate of the Loyola University Stritch School of Medicine.

***Payne, Helen V.,** Chicago, died March 22, 1981 at the age of 64. Dr. Payne was a 1942 graduate of Harvard University.

***Ramsay, Samuel W.,** Chicago, died January 1, 1981 at the age of 84. He was a 1924 graduate of the Loyola University Stritch School of Medicine.

****Rappaport, Ben Z.,** Highland Park, died April 26, 1981 at the age of 84. He was a 1923 graduate of the University of Illinois.

***Shufflebarger, Forrest G.,** Chicago, died March 17, 1981 at the age of 76. He was a 1936 graduate of Northwestern University.

****Somers, Harry V.,** Chicago, died March 23, 1981 at the age of 83. He was a 1925 graduate of the Loyola University Stritch School of Medicine.

****Tarnawski, Alex,** Elgin, died April 27, 1981 at the age of 84. He was a 1930 graduate of the Loyola University Stritch School of Medicine.

***Weissman, Louis,** Chicago, died April 16, 1981 at the age of 66. He was a 1940 graduate of the Chicago Medical School.

***Zajdzinski, Sigmund V.,** Chicago, died April 21, 1981 at the age of 78. He was a 1932 graduate of the Chicago Medical School.

* Indicates ISMS member
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Illinois Housestaff News

The Art of Professionism

By David Olive, M.D./Evanston
Delegate, ISMS/RPS

The title "professional" is a prominent standard of achievement in our society. The historic "respectability" of a white collar job has been replaced by the desire to become a professional. If one examines the etymology of the word profession, it becomes apparent that medicine was one of the first groups to gain professional recognition in the sense that the term is used today. It is also clear that medicine has often served as the norm by which all other professional groups are judged. Analysis of the development of medicine as a profession has produced criteria by which the term is defined.

The pioneer sociological work on the subject of professions was by Carr-Saunders and Wilson in 1933. They and others have concluded that the key attributes of a profession are (1) possession of specialized techniques for giving service to those served; (2) acquiring the techniques through a substantial program of intellectual study; (3) basing the techniques upon a body of scientific knowledge with ongoing research; (4) the ability to enforce standards and control access to the occupation and (5) reimbursement by salaries or fees for service, rather than making a profit. More peripheral characteristics include authority, prestige, and a code of ethics.

Notably missing from the criteria is creation of specialized terminology. This is one area in which medicine has excelled. In an attempt to emphasize its differences from other competing groups, medicine originally resorted to Latin. Today, the obfuscation is couched in Latin-derived scientific terminology. At no point was the objective of such specialized terms to provide a better understanding for patients. The effect was just the opposite, to help create the "mystique of medicine." Much of this mystique has been incorporated into educational programs, with the result that medical education now includes an initiation into the secrets of the profession and a development of an "in group" point of view. Evidence of such is seen in the use of terms such as "erythematous" rather than the equally descriptive "red." Patients don't scratch an "itch", they scratch "pruritis." It appears that the mystique of medicine is as strong as ever. Moreover, as anxiety regarding professional status increases, members of the profession appear to adhere even more rigidly to such nonprofessional devices.

Recently, there has been a push by other groups involved in health care to attain professional status. Interestingly, among the initial tacks taken by such groups of workers is the creation of a unique, elitist terminology. "Patients," according to the nursing profession, become "clients." Why? Ostensibly because the term is less unidirectional; less condescending than patient.

But in fact, client is defined as a person *depending upon another,* whereas a patient is a person receiving care or treatment (Webster's New World Dictionary, Second College Edition). It appears that nursing has discarded a term closely aligned with their intent in favor of one which is much less acceptable in definition. However, a great deal of importance is seen in the fact that client is a new and different term, a word which helps set the nursing profession apart from medicine. Similar thinking results in surveys used in patient research being termed "tools" by nursing, and "instruments" by social workers.

Such unnecessary semantic equivocation might be termed the art of "professionism;" that is, an attempt to define a profession by sleight of hand. If those in medicine, nursing, social work, and other health care groups truly believe that they are professionals, they must recognize that utilizing such a technique only obscures the real issues. Specialized language for its own sake is merely professionistic impersonation, and no group relying upon such a device will ever achieve professional recognition when examined with scrutiny. The time has come for such groups to promote their professionalism along established, accepted criteria. After all, these criteria are the real strength of the profession. ◀

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Dr. Thomas Harwood, physician advisor, Illinois Society and Master of Ceremonies, Inaugural Banquet, and Mrs. Harwood.



Luella Mitchell, (L) Illinois Society speaker of House of Delegates with Dr. Tibor Czeisler, president, South Cook County Branch, Chicago Medical Society, and Mrs. Czeisler.



Dr. Robert Hartman, ISMS liaison & physician advisor, and Mrs. Hartman.



Dr. & Mrs. Eugene Scherba and Dr. Basilio Bolumen, physician employers and guests.

Surgery

Fiberoptic Colonoscopy
For: Surgeons, Internists, FP's. Lecture, August 5 (2 ½ days), Chicago. **Speaker:** Herand Abcarian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 80612. **Fee:** $400. **Reg. limit:** 40. **Credit:** Category 1, 15 hours. **Contact:** Robert Bakar, MD. **Phone:** 312/733-2800.

Surgery

Coagulation Problems Related to Preoperative Procedures
For: MD's. Lecture, August 7, Chicago. **Speaker:** Hau Kwaan, MD. **Sponsor:** Grant Hospital, 550 W. Webster, Chicago 60614. **Credit:** Category 1, 1 hour. **Contact:** Robert Mutterperl, DO.

SEPTEMBER

Chest Diseases

Symposium on Pulmonary Diseases
For: MD's. Symposium, Sept. 4, 11, 18 & 25, Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Charles Waigel, MD. **Phone:** 312/3BB-7870.

Hypnosis

Workshops on Clinical Hypnosis
For: MD's. Workshop, Sept. 17-20, St. Louis, MO. **Sponsor:** American Society of Clinical Hypnosis, Education and Research Foundation, 2400 E. Davon Ave., Suite 218, Des Plaines 60018. **Fee:** $295. **Reg. limit:** none. **Credit:** Category 1, 25 hours; AAFP Elective, 25 hours. **Contact:** William Hoffman, Jr. **Phone:** 312/297-3317.

Internal Medicine

Internal Medicine of the 1980's
For: Internists, FP's, GP's. Workshop, Sept. 21-23, Chicago. **Speaker:** Ruy Lourenco, MD. **Sponsor:** U of I, CME, 1B53 W. Polk St., Rm. 144, Chicago 60612. **Reg. deadline:** 9/7. **Reg. limit:** 200. **Fee:** $250. **Credit:** Catagory 1, 1B hours; AAFP Elective, 1B hours. **Contact:** Sue Korienek. **Phone:** 312/996-8025.

Medicine

Clinical Refresher Course
For: GP's. Coursa, Sept. 23-26, Chicago Marriott Hotel. **Sponsor:** Chicago College of Ostaopathic Medicine, 5206 S. University Ave., Chicago 60615. **Reg. deadline:** 9/22. **Fee:** $200. **Reg. limit:** none. **Credit:** AOA, 21 hours. **Contact:** Marie Kowalsky. **Phone:** 312/947-4800.

Medicine

Breast Cancer Update
For: MD's. Lecture, Sept. 25, Chicago. **Speaker:** Barry Goldsmith, MD. **Sponsor:** Grant Hospital, 550 W. Webstar, Chicago 60614. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Robert Muttarparl, DO.

Medicine

Office Dermatology
For: MD's. Symposium, Sept. 29, 7:00 p.m., Vandalia. **Sponsor:** SIU School of Medicine, B01 N. Rutladge, Rm. 4241, Springfield B270B. **Reg. limit:** none. **Credit:** Catagory 1, 4 hours. **Contact:** Lorraine Staphenson. **Phone:** 217/782-7711.

Medicine

Advance Life Support Other Than ACLS
For: MD's. Symposium, Sept. 26, Ina. **Sponsor:** SIU School of Medicina, 801 N. Rutledge, Rm. 4241, Springfield B270B. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/7B2-7711.

Medicine

New Advances in Cardiac Emergencies
For: MD's. Symposium, Sept. 23, 6:00 p.m., Wood River. **Sponsor:** SIU School of Medicine, B01 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/7B2-7711.

Medicine

Stroke Symposium
For: MD's. Symposium, Sept. 23, 1:00 p.m., Nashville. **Sponsor:** SIU School of Medicine, B01 N. Rutledge, Rm. 4241, Springfield B270B. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraina Staphanson. **Phone:** 217/7B2-7711.

Medicine

Perinatal Workshop
For: MD's. Symposium, Sept. 1B-19, Springfield. **Sponsor:** SIU School of Medicine, B01 N. Rutladge, Rm. 4241, Springfield B270B. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Cardiology Symposium for Physicians and Nurses
For: MD's, RN's. Symposium, Sept. 17, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, B01 N. Rutledge, Rm. 4241, Springfield 6270B. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/7B2-7711.

Medicine

Nuclear Medicine
For: MD's. Symposium, Sapt. 16, Marion. **Sponsor:** SIU School of Medicine, B01 N. Rutledga, Rm. 4241, Springfield B2708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Caring for the Older Patient
For: MD's. Symposium, Sept. 12, 1:00 p.m., Flora. **Sponsor:** SIU School of Medicine, B01 N. Rutledge, Rm. 4241, Springfield B2708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephanson. **Phone:** 217/7B2-7711.

Medicine

Adult and Childhood Anemias
For: MD's. Symposium, Sept. 10, 9:00 a.m., East St. Louis. **Sponsor:** SIU School of Medicine, B01 N. Rutledge, Rm. 4241, Springfield 6270B. **Reg. limit:** none. **Credit:** Catagory 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/7B2-7711.

Pediatric Neurology

Pediatric Neurology in Daily Clinical Practice
For: MD's. Seminar, Sept. 30, Maywood. **Sponsor:** CME, Loyola University of Chicago, Stritch School of Medicine, 2160 S. First Ave., Maywood 60153. **Fee:** $125. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours. **Contact:** Linda Gunzburger, PhD. **Phone:** 312/531-3236.

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Pulse of the ISMS Auxiliary

The First 60 Days

From The Desk of the President

BY BONNIE KEEGAN, ISMSA PRESIDENT

As I try *taking one step at a time* and step into the shoes of my predecessor, I find that travel down the Yellow Brick Road is filled with many side trips.

Immediately after the Annual Meeting, I began traveling to out-of-state conventions in the North Central Region. This travel is necessary to provide cohesiveness of our region (which includes Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota and Wisconsin) and to share ideas and programs to promote health awareness and wellness. The future holds the possibility of launching simultaneous programs and the use of mass media coverage. The auxiliary can and will be making a larger impact on health.

I have had the opportunity through travel to meet the Medical Society officers of the North Central Region and to observe each state's health program. I have observed that the introduction of the "Shape-Up for Life" program has increased our own and also the public's awareness of good health and wellness. This is very apparent in each state.

The numbers in the Auxiliary are slowly increasing. Our membership in Illinois has increased this past year enough to gain another delegate (voice) at the 1981 AMAA meeting. Those who have been elected to represent Illinois are shown in the next column.

Mrs. Harold Keegan (Bonnie) Chairman
Mrs. Harlan Failor (Pat)
Mrs. Don Hinderliter (Diane)
Mrs. Gamil Arida (Ann)
Mrs. Joseph Cari (Elaine)
Mrs. Donald De Pinto (Irene)
Mrs. R. Samuel Hoover (Sheila)
Mrs. Wayne Kassel (Lynn)
Mrs. Earl Klaren (Jane)
Mrs. William Simmons (LaVerne)
Mrs. Irvin Blumfield (Barbara)
Mrs. Selig Hodes (Evelyn)

Issues of this annual meeting will be child restraint safety, membership and cost containment.

We, 3200 spouses, can be a formidable voice in future legislative decisions concerning health care. I have met some very dynamic and articulate auxilians and see a place for them in future legislative efforts.

I have attended the meetings of Will-Grundy, Du Page and Cook Counties and find that all are facing change. I feel part of our responsibility will be to support the auxiliaries as they face changing times in health.

These 60 days have enlightened me to the fact that there is a tremendous amount of business that must be conducted. I am learning to cope (stress management) and will keep heading down that road "one step at a time". ◄

Viewbox

(Continued from page 364)



Figure 2

In this patient, a very poor surgical candidate, biliary drainage was established by the percutaneous introduction of a drainage catheter immediately following the percutaneous cholangiogram. The catheter was successfully advanced past the apparent point of obstruction and positioned within the duodenum. Multiple side holes in the catheter above the obstructive lesion permit entrance of bile into the catheter. This will allow drainage of bile both externally into a collection bag and internally into the patient's gastrointestinal tract to aid in maintenance of a relatively normal nutritional status and electrolyte balance.

At the time cholangiography was done, filling defects compatible with stones were not present

(Continued on page 396)

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**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*. IMS America Ltd., September 1980.

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Rectal Cream with Hydrocortisone Acetate
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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
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Prolonged or excessive use of corticosteroids might produce systemic effects.
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In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
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NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
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Viewbox

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but the appearance of the common duct suggested a neoplastic etiology for the obstruction. The duodenal sweep also appeared abnormal. For these reasons, a pancreatic cancer was suspected and the patient will probably not undergo further definitive surgery. Percutaneous biopsy of the pancreas could be used to establish the diagnosis.

Percutaneous opacification of the gallbladder was reported by Burcharth and Miller (Germany, 1920). Percutaneous transhepatic cholangiography was introduced by Huard and Do Xuan-Hop (Vietnam, 1937). Opacification of the biliary tract by these two approaches gained only limited acceptance in the evaluation of the jaundiced patient because of associated complications such as hemorrhage, sepsis, bile peritonitis and death, and also because of the relatively complicated procedures (surgery or peritonedscopy) required to puncture and inject the gallbladder. Many authors have reported experiences with these basic techniques. Whether or not they favored the procedure in evaluation of the jaundiced patient depended on success in opacifying the biliary tree and complications encountered. Many recommended that the procedure be done only just before taking the patient to the operating room for definitive surgery to avert bile peritonitis.

In 1964, Wiechel of Sweden reported his experience using percutaneous cholangiography.[1] His technique included use of a sheathed needle and a lateral rather than subcostal puncture site. These modifications eliminated or diminished the risk of gallbladder puncture and laceration of the liver as a consequence of respiratory motion. Additionally, the sheath could be left in place in the liver for prolonged periods of time to promote drainage of bile externally as well as prevent hemorrhage from the puncture site. Finally, surgery could be postponed in the poor risk patient until his general condition could be improved. He reported successful opacification of the biliary tree in over 90% of patients studied.

In 1974, Molar and Stockum reported their experience extending diagnostic PTC to a therapeutic modality.[2] These authors advocated angiographic techniques to advance drainage catheters further into the biliary tree after percutaneous cholangiography as well as advancing drainage catheters past an obstructing lesion if present. In 1976, Burcharth and Nielbo (and in 1978, Burcharth alone) reported their results using similar techniques.[3,4]

The placement of a very flexible catheter deep in the biliary tree allowed introduction of contrast material in adequate concentrations to permit very accurate assessment of the point of obstruction in the biliary tree and its probable cause. In selected patients, a long term external and/or internal drainage could be established. In patients deemed inoperable, jaundice and pruritis could be relieved without subjecting the patient to surgical procedures accompanied by considerable morbidity and mortality. It was no longer necessary that patients with operable lesions be routinely rushed to surgery.

In 1974, a technique of percutaneous cholangiography using a very fine gauge, flexible needle was introduced by Okuda, *et al,* of Japan.[5] The advantage of this method over those previously described was the very low complication rate. The work of these authors heralded a resurgence of interest in applications of percutaneous cholangiography in diagnosis of the jaundiced patient. Using this type of needle many authors have now reported visualization of virtually 100% of obstructed ducts and 70% or more of non-dilated ducts.[6,7] Obviously it was not long before this technique was combined with a drainage procedure as advocated by earlier and contemporary authors. Today this combined approach is practiced in many radiology departments throughout the world and a variety of benign and malignant conditions involving the biliary tree have been successfully treated or palliated. In benign conditions, drainage is established prior to definitive surgery, allowing time for the patients' nutritional status to improve and for superimposed cholangitis to clear. Benign strictures have been successfully dilated through this portal, and ductal stones have been removed. In patients with malignant disease, successful drainage of the obstructed biliary tree will frequently bring relief of jaundice and pruritis. More importantly, percutaneous drainage can obviate the need to embark upon surgery associated with relatively high rates of morbidity and/or mortality when there is no prospect of prolonging life.[8-11] Lengthy and expensive hospitalizations can be minimized, allowing patients who have a limited life expectancy to return home with relief of symptoms due to biliary obstruction. ◀

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Doctor's News

ERRATA—Last month's Doctor's News erroneously reported the newly elected officers of the Illinois State Medical Insurance Exchange Board of Governors. **Fredric D. Lake, M.D.,** Evanston, was re-elected chairman of the Board of Governors; **Robert R. Hartman, M.D.,** Jacksonville, will serve as vice-chairman and **Julian W. Buser, M.D.,** Belleville, will serve as secretary. The *Journal* apologizes for this error.

PHYSICIANS IN THE NEWS—**Harold A. Sofield, M.D.,** Oak Park, received the AMA's Dr. Rodman E. Sheen and Thomas G. Sheen Award for 1981 during the June 7 meeting of the AMA House of Delegates. The award, presented annually to a physician in recognition of scientific accomplishment, includes a plaque and $15,000 stipend ISMS nominees to AMA Councils during this year's annual meeting are **L. Ann Nunnally, M.D.,** Chicago, nominated to the Council on Medical Education and **Joseph H. Skom, M.D.,** Chicago, nominated to join the Council on Scientific Affairs.

Richard H. Moy, M.D., Springfield, received a special award from the Society of Teachers of Family Medicine during their annual May meeting in San Diego. The award recognized Dr. Moy's outstanding service to the aims and principles of the Society in his capacity as dean and provost of the SIU School of Medicine.

Twelve Illinois physicians were recently named fellows of the American College of Physicians. Inducted to fellowship at the ACP annual meeting in April were: **John F. Moran, M.D.,** Burr Ridge; **William D. Barnhart, M.D., Peter Bright-Asare, M.D.** and **Jack M. Bulmash, M.D.,** Chicago; **Wei-Tzuoh Chen, M.D.** and **Mushtaq A. Khan, M.D.,** Downers Grove; **Paul A. Greenberger, M.D.** and **Sam J. Sugar, M.D.,** Evanston; **Anthony L. Barbato, M.D.,** Oak Park; **Subhash Popli, M.D.,** Oak Brook; **William J. Arnold, M.D.,** Park Ridge and **Gamini S. Sooriyaarachchi, M.D.,** Rockford.

DRUG PRODUCTS UPDATE—The Illinois Department of Public Aid has announced that preparations containing Phenacetin were deleted from the Drug Manual effective April 1, 1981. This action is in concert with recommendation of the ISMS Committee on Drugs and Therapeutics, based upon demonstrated renal toxicity.

SPECIAL ACCREDITATION ANNOUNCED—The Field Medical Group, Chicago, recently became the only multi-specialty group practice clinic in Chicago, and one of five ambulatory health care organizations in the city, to be awarded accreditation by the Accreditation Association for Ambulatory Health Care, Inc. The clinic received a three-year accreditation, which represents the highest level of compliance with AAAHC standards, and a special commendation.

ISMS TRAVEL PROGRAM UPDATE—Reservations on the 1981 Alaskan Cruise, departing San Francisco on August 29 and returning September 12, are now available to ISMS members. The fourteen day cruise, which includes all meals and accommodations, is available at a range of packages from $1995 to $3575 per person. (The cost is determined by the size and location of sleeping rooms, as well as double and single occupancy.) A special Air-Sea Program package provides round trip flights from six midwest cities to San Francisco at a special rate, which includes transfers from the San Francisco Airport and Pier. A deposit of $300 per person is required. Further information may be obtained by contacting the ISMS offices, Division of Education and Manpower, (312) 782-1654.

ENGLISH PRONUNCIATION SEMINAR SCHEDULED—The third annual AMA seminar on improving english pronunciation for foreign medical graduates will be held Saturday July 18, 9:00-4:30, at AMA headquarters in Chicago. Registration for AMA members is $130, with cost of $170 and $80 for non-members and residents, respectively. A 134 page manual and nine home study tapes are provided. Further information may be obtained by contacting Henry Mason, Division of Professional Relations, AMA, 535 N. Dearborn, Chicago 60610.

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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

July 14 •	Lutheran General Hosp. & A.C.S.	Park Ridge
August 3	Christ Hosp. & A.C.S.	Oak Lawn
Bi-Monthly	Skokie Valley Hosp.	Skokie
August 3	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
August 24	YWCA	Rockford
September 7	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
September 8	St. Francis Hosp. & A.C.S.	Blue Island
October 5	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
October 5	Lake Forest Hospital & A.C.S.	Lake Forest
October 12	Christ Hospital & A.C.S.	Oak Lawn
October 19	Sherman Hospital & A.C.S.	Elgin
October 20	Decatur Memorial Hospital & A.C.S.	Decatur
October 20	Lutheran General Hosp. & A.C.S.	Park Ridge
October 26	St. Francis Hospital & A.C.S.	Evanston
December 7	Christ Hospital & A.C.S.	Oak Lawn

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FAMILY PRACTICE GROUP seeks pediatrician to join rapidly expanding practice 50 miles northwest of Chicago. Salary open. Fringe benefits. Call 815-338-7210 for interview.

EMERGENCY MEDICINE POSITION AVAILABLE: Emergency physician to join professional group practicing in superior emergency department in Aurora, Illinois. Contact Dr. Alan B. Spacone at (312) 323-3083 or Emergency Treatment, S.C. at (312) 327-0777.

INTERNIST/FAMILY PRACTITIONER—To join Internist and General Surgeon in private practice. Actively growing hospital with medical school affiliation. Contact: Masood Akhtar, M.D., F.A.C.S., Michael L. Treece, M.D., 607 W. Main Street, Carbondale, Illinois 62901. Call Collect: 618-549-2713.

EMERGENCY MEDICINE—TERRE HAUTE, INDIANA: Directorship opportunity available 7-1-81 in modern, moderate volume trauma center with excellent specialty and subspecialty support. This metrpolitan community offers many educational, recreational, and cultural amenities. Annual minimum guarantee plus production based bonus (i.e. fee-for-service). Paid malpractice insurance; flexible scheduling with no on-call involvement. For details send credentials in confidence to John Kutchback, 970 Executive Parkway, St. Louis, MO 63141 or call toll-free 1-800-325-3982.

WANTED: Experienced physician interested in buying a general and industrial practice or ownership of industrial clinic in northwest or southwest of Chicago. Excellent financial package. Contact Box 997, Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

WHOLISTIC HEALTH CENTER in LaGrange, IL needs physician medical director for a church based medical clinic working with a team of four nurses, an administrator, pastoral counselor and a staff of volunteers. To begin June 1—salary negotiable. Call Jason Reed at (312) 579-0616.

FAMILY PRACTITIONER or General Practitioner wanted to join practice in beautiful riverside community in central Illinois. Liberal guarantee with many opportunities. Community has modern 50 bed hospital with excellent educational and recreational opportunities. Please contact: W. J. Hurteau, Administrator, Mason District Hospital, Havana, Il. 62644, 309-543-4431.

FAMILY PHYSICIAN wanted to join two Board Certified family physicians and one physician assistant in a young and growing medical practice in Central Minnesota. The practice is oriented towards family medicine. The practice is located centrally in the state with quick access to Minneapolis/St. Paul. Cultural and recreational activities are in abundance in this area of Minnesota. Salary open. Contact Daryl G. Mathews, Adm., or Thomas J. Newton, M.D. at the Cold Spring Medical Clinic—26 N. Red River Ave., Cold Spring, MN 56320. Call 612-685-8641.

FAMILY PRACTICE—A nine physician multi-specialty group seeks a family practitioner to staff a satellite clinic 85 miles west of Chicago. A fully equipped clinic with office personnel is provided. A negotiable guaranteed minimum salary for the first year and substantial benefits are offered. Practice includes option of no on-call responsibilities. Reside either in a small community or in a growing city of over 30,000. For information call Tom Campbell, Fox Hill Associates, Ltd., (collect) 414/255-6500 (office) or 414/662-4147 (home).

GENERAL SURGEON—Eight-doctor multi-specialty clinic in midwestern community, serving a population of 30,000, has an opening for a general surgeon. Located within 30 miles of medical school, universities and state capitol. Contact Box #1006 c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

ASSISTANT DIRECTOR—Innovative and expanding Family Practice Residency affiliated with Southern Illinois University. Generous salary and fringes for M.D. Minimum three years experience or Family Practice Residency; Board Certification desirable. Assistant professor or higher rank depending on background. Administrative, teaching, and practice responsibilities. Reply to: J. Paul Newell, M.D., Director, Belleville Family Practice Center, 219 South Illinois Street, Belleville, IL 62220 (618) 233-5480. SIU School of Medicine is an Equal Opportunity/Affirmative Action Employer.

STAFF PHYSICIAN—Student Health Service. Full-time position, 11 month continuing contract. Illinois license. Good benefits with 40 hour week—no night call. Salary competitive. Contact: Paul R. Nelson, M. D., Student Health Service, Illinois State University, Normal, IL 61761 (ph. (309) 438-8655). An equal opportunity/affirmative action university.

SUMMER LOCUM TENENS—EMERGENCY MEDICINE—Clinical physician sought for moderate volume emergency department located in picturesque Mississippi river town in Northeastern Missouri. Monday-Friday; 6 a.m. to 6 p.m. Attractive compensation and professional liability insurance provided. For further details, send credentials in confidence to Michelle Grimm, 970 Executive Parkway, St. Louis, MO 63141; or call toll-free 1-800-325-3982 (in Missouri call collect 314-878-2280).

MIXED MULTI-SPECIALTY INCORPORATED GROUP—30 miles south of Chicago seeks Family Practitioner. Life, disability, malpractice insurance and all medical dues paid. X-ray and lab in building. Excellent hospital facilities half block from office. Salary, profit sharing and pension plan $54,000. Partnership after one year. Write or call collect, Mr. E. Karmis, 1400 Otto Blvd., Chicago Heights, Illinois 60411. Phone (312) 756-4400.

INTERNIST: Board eligible or certified—opportunity to join busy Internist in downstate Illinois community. Large general internal medicine practice. Salary leading to partnership. Send brief CV with inquiry to Box 1007, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

MISSOURI, ST. LOUIS: Emergency Medicine directorship available in moderate volume ED. Enjoy an excellent guaranteed income, paid professional liability insurance, and flexible scheduling without on-call involvement. Additional stipend for director's responsibilities. For details, send credentials in confidence to Michelle Grimm, 970 Executive Parkway, St. Louis, MO 63141; or call toll-free 1-800-325-3982.

EMERGENCY MEDICINE OPPORTUNITIES—available in Metro St. Louis Area—Directorship and clinical positions in lovely bedroom community. Excellent income based on departmental productivity, paid liability insurance, and flexible hours with no on-call responsibilities. For details, send credentials in confidence to Michelle Grimm, 970 Executive Parkway, St. Louis, MO 63141; or call toll-free 1-800-325-3982.

PARTNER WANTED—Older G.P. Ready to retire gradually. Needs young physician in his busy and lucrative practice, located in a city of less than 5,000 people. Five miles from 2 open staff hospitals in southern Illinois "Little Egypt" area, no financing needed. Send replies to Illinois Medical Journal, Box 1008, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

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PHYSICIAN—ORTHOPEDIC SURGEON—$80,000/year—70 hours/week. Practice in a modern medical clinic; completion of recognized specialty training in orthopedic surgery; licensability and highly acceptable references required. Contact: Job Service, Franklin Square, Quincy, Illinois 62301.

EMERGENCY PHYSICIAN (South-central Illinois)—needed for medium-volume emergency and trauma department. Join two full-time emergency physicians on an independent contract basis. Wholesome small community environment, ideal for one who prefers a predictable professional pace, leaving room for an improved personal and family life. Call Fred Kopp collect at (414) 255-6500.

EDITOR/WRITER, New Publication. Science and/or Nursing Background. Knowledge of Cancer Treatment and Research. Salary to high 20s. Must be willing to relocate to Indianapolis. Write to: D. Mark Robertson, P.O. Box 567B, Indianapolis, Indiana 46206.

SITUATIONS WANTED

RADIOLOGIST trained in diagnostic modalities including CT Scanner, and Ultrasound seeks full or part time position in small community hospital. Contact Box 989 c/o Illinois Medical Journal, 55 E. Monroe, Chicago, IL 60603.

BOARD CERTIFIED radiologist available in Chicago and suburbs for fluoroscopy and film reading in clinic or hospital. Same day pick-up and delivery. Excellent references. Personal service. Reply Box 998 c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, IL 60603.

PEDIATRICIAN—32, completing residency. Extensive exposure to internal and emergency medicine. Two years rural experience. Partial general practice agreeable. Available July. Write Box 1001, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.

SEEKING MEDICO-LEGAL, admin. or phys. exams. 25 yrs. Gen. Pract., 10 yrs. medico-legal with hosp. liability and chart review and some industrial exp. Contact Box No. 1011, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.

YOUNG E.N.T. SPECIALIST desires relocation to North or Northwest Suburban Chicago area, full or part-time. Contact Box No. 1010, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.

FOR SALE, LEASE OR RENT

PROFESSIONAL OFFICE SPACE for rent in South Elgin, Ill. New building, second floor, with elevator. Four months free rent with 5-year or longer lease. 312/742-8009 or 742-8901.

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OFFICE SPACE AVAILABLE for General Surgeon and OB/GYN practice in attractive medical office building with lab and X-ray facilities. Located in Fairview Heights Medical Arts Building, 10700 Lincoln Trail, Fairview Heights, IL 62208 or call (618) 397-2750.

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EKG

(Continued from page 382)

Answers: 1. C. D. E. 2. E.

In the top ECG strip, the bar marks the start of an exercise induced paroxysmal supraventricular tachycardia. ST segment depression is more marked in these beats than in the sinus beats. As the treadmill is slowing down, in the middle ECG strip, the supraventricular tachycardia spontaneously breaks to a sinus tachycardia. The maximal heart rate in sinus rhythm was 140 beats per minute. In the lower ECG strip the sinus rate is approximately 120 beats per minute when the premature ventricular beats develop. The fourth, fifth and sixth beats are ventricular in origin. Another burst of five ventricular beats occurs toward the end of this lower ECG strip. These represent short bursts of ventricular tachycardia. In the last bout of ventricular tachycardia, the beats are multifocal; some have a positive and others a negative polarity. ST segment depression in exercise is only valid when seen in sinus beats. In patients with the mitral valve prolapse, ST segment depression can often be false positive and not represent an ischemic response. Palpitations and arrhythmias are very common in patients with mitral valve prolapse. Propranolol is regarded as the treatment of choice although diphenylhydantoin may also be useful. Multistage exercise testing can aid in the detection and definition of these arrhythmias. In our patient propranolol caused a sinus bradycardia which allowed more extrasystoles to be manifest. A combination of digoxin and quinidine controlled the arrhythmias. Follow-up exercise testing with a maximal heart rate of 167 beats per minute failed to demonstrate any ventricular arrhythmia and only a very short burst of supraventricular tachycardia. All of the answers in question 2 are correct. For further reading on this interesting problem see *American Journal of Cardiology* 29:611, 1972 and *American Journal of Medicine* 60:961, 1976. ◀

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IMJ Attention

LEGAL REFORMERS EXULT — Legislation to bring greater equity to the counterclaim process has passed the House of Representatives by a vote of 129/22, with 11 representatives voting present. House Bill 1155, sponsored by Rep. Sam Vinson (R-Clinton) is intended to remove barriers preventing a wrongfully sued professional from bringing a countersuit. The bill would amend the Civil Practice Act by allowing defendants to sue for damages incurred in defending a malpractice claim. Further, if the suit was brought in a willful and wanton manner, HB 1155 would permit exonerated defendants to sue for punitive damages and to sue the plaintiff's counsel as well. Physicians should contact their state Senators urging a favorable vote.

Further progress toward legal equity in medical malpractice is marked also by House passage of HB 1029, sponsored by Rep. Lee Daniels (R-Elmhurst). That bill would amend the Civil Practice Act regarding the *res ipsa loquitur* ("the thing speaks for itself") doctrine in medical and dental malpractice cases. HB 1029 would require that the court, in determining whether or not to allow a plaintiff's *res ipsa* basis for bringing suit, would not accept simple proof that an unusual, unexpected or untoward medical result occurred. In order to bring a *res ipsa* case, the plaintiff would be required to show also that the result would *not* have occurred absent negligence on the part of the defendant. The House approved HB 1029 by a vote of 103/26, with 18 members voting present. It will now be considered by the Illinois Senate.

House passage of HB 1365 is the third positive malpractice-related action to report this month. The House voted 143/9 (one voting present) to pass this bill on to the Illinois Senate. Sponsored by Rep. Lee Daniels (R-Elmhurst) HB 1365 would reinforce confidentiality protections for hospital peer review committees. Current provisions of the Medical Studies Act, which is intended to protect the minutes and discussions of such committees from discovery, were weakened by a recent court action.

An amendment to HB 845, sponsored by Rep. Pat Grossi (R-Glenwood) is also pertinent to the malpractice arena. As first written, HB 845 would have required interest payment on all judgments commencing the date of the alleged incident on which action was brought. (Current law requires that 9% interest be paid the plaintiff from the time of verdict until judgment is paid.) The bill would have had a huge impact on medical malpractice claims, which sometimes pend for years before trial and verdict. The amended version of HB 845, which excludes all professional malpractice from its provisions, pends for House action next Spring.

MARCH CPI FIGURES RELEASED — The Bureau of Labor Statistics' Consumer Price Index shows that physician fees increased by .9% in March, exceeding the percentage increases in the all items component (.7%) and the all services component (.8%). Over the past twelve months, AMA reports, the physicians' services index was found to have risen 10.7%, while the all services index increased by 11.9% and the all items index by 10.6%.

VALUING A MEDICAL PRACTICE — is the title of a new AMA booklet which provides guidelines to assessing the elements that determine the worth of a practice to be sold or purchased. The booklet covers assets from earnings and equipment to leases and good will. *Valuing a Medical Practice* may be obtained by writing the AMA Order Dept., OP-117, PO Box 821, Monroe, Wisconsin 53566. (Costs are $5 for 1-10 copies and $4.50 for 11-49 copies.) Handling fees are $1.50 for orders under $11 and $2 for those exceeding that amount.

NEWS FROM WASHINGTON —The AMA reports that the Senate Finance Committee has taken major actions in health funding. One recent vote cut Medicaid spending in the next fiscal year by $800 million by decreasing the federal contribution to states from 50% to 40%. Concomitantly, the Committee voted to cap federal outlays for the program at 9%, to raise Medicare Part B deductibles and premiums, reduce the Medicare nursing differential by nearly half and force retired federal employees' private health insurance to reimburse before Medicare payments initiate. It is estimated that $4.2 billion Medicare dollars would be saved under these provisions. Similar proposals will be considered by the House Ways and Means Health Subcommittee.

The House Commerce Health Subcommittee has approved legislation to phase out new federal grants for HMOs. The approved package also removes mental health, drug and alcohol abuse treatment from the list of required services.

JCAH STANDARDS TO BE REWRITTEN— The Board of Commissioners of the Joint Commission on Accreditation of Hospitals has voted to rewrite their standards in order to focus on elements essential to quality patient care and to address concerns regarding unnecessary requirements and ambiguity. The sections on governing body, medical staff, nursing services, medical record services, management and administrative services and building and grounds safety will be addressed initially. JCAH is also planning to explore changes in the survey process, including possible lengthening of the accreditation cycle, and tailoring surveys to the nature and needs of individual facilities.

IDPA IMPLEMENTS NEW SYSTEM — Medicaid Management Information Systems (MMIS) is a new computer billing system which will process all Illinois Department of Public Aid claims. IDPA advises that the system was scheduled for implementation July first in St. Clair County, August 15 in Cook County and September 15 in the balance of the state.

Packets containing forms for re-enrollment in the Illinois medicaid program have been mailed to St. Clair and Cook County physicians. Completion of these forms is required for continued billing through IDPA. Physicians in St. Clair and Cook counties who have not yet received their enrollment packets should contact the Illinois Department of Public Aid, Post Office Box 4037, Springfield 62708. Their toll-free number is 800-252-8937.

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Illinois Medical Journal

OFFICIAL JOURNAL OF THE
ILLINOIS STATE MEDICAL SOCIETY
Volume 160, No. 1, July 1981

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PRECAUTIONS: As with other antibacterial prepa tions, prolonged use may result in overgrowth of n susceptible organisms, including fungi. Appropri measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not common cutaneous sensitizer. Articles in the curr literature indicate an increase in the prevalenc persons allergic to neomycin. Ototoxicity and nepl toxicity have been reported (see Warning section).

Complete literature available on request from Pro sional Services Dept. PML.

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REPORT FOR *Illinois Physicians*

'DIRECT ADMISSION' PILOT PROGRAM BROADENED

More than 120,000 persons covered by Illinois Blue Cross and Blue Shield benefit programs now are eligible for direct admission to specialized care facilities.

Under the "direct admission" program, members are covered for medically necessary care in an Illinois Plan approved, participating Skilled Nursing Facility (SNF) or Coordinated Home Care (CHC) program without first having to be a hospital inpatient.

The direct admission program was reinstated earlier this year on a one-year pilot basis (ending February, 1982) for the employees of the Chicago Board of Education.

However, five other groups were added to the pilot program recently. They include employees of the Chicago Park District, the Metropolitan Sanitary District, Jewel, Inc., the Cook County offices and Libby, MacNeill, and Libby, Inc.

The required hospital stay prior to transfer to a specialized care facility has been waived for these groups. However, the attending physician must certify that skilled care is required and that this care can be provided in an SNF or CHC program.

The Illinois Plan will analyze the results after the one-year pilot program is concluded to determine its cost effectiveness. If the results are positive, the direct admission program could be made available to all of its groups

All covered benefits under the regular SNF and CHC programs remain the same, as do the billing procedures. Questions regarding billing of office visits, visits to the home or SNF should be directed to Bill Livingston, Professional Relations Department, Blue Cross and Blue Shield, 233 North Michigan Avenue, Chicago, Illinois, 60601 or (312) 661-4488.

If physicians have a patient whom they may be planning to admit to an acute care hospital, the patient's needs may be met in an SNF or CHC program. Please contact Bill Livingston to determine group eligibility or for a list of approved, participating SNF facilities.

SOME BENEFITS CHANGE FOR STATE EMPLOYEES HEALTH PLAN

The Illinois Blue Cross and Blue Shield Plan has been awarded a new two-year contract to administer the group health insurance program for State of Illinois employees and their dependents.

One of the major changes made by the state in the new contract, effective July 1, 1981, provides that no benefit payments will be made for selected inpatient surgery which could have been performed on an outpatient basis. Any deviation from the contract provision requires a statement from the doctor giving medical reasons for the inpatient procedure.

The new contract also changes the benefit structure. Where the old contract provided payment for any surgical procedure on an 80 percent Usual and Customary basis, the new contract calls for an 80 percent U & C inpatient payment and 100 percent U & C for procedures performed on an outpatient basis.

Members enrolled in the Plan's State Employees program have a 42500 group identification number and a Social Security number. Both numbers should be used in filing claims.

For your information, the following represents some of the surgical procedures which frequently can be performed in an ambulatory setting:

Abdominal paracentesis
Antrum irrigations
Arthrocentesis
Arthrography and arthroscopy
Aspiration of Douglas's cul-de-sac
Bartholin cyst excision, marsupialization or I&D
Bladder puncture aspiration
Blepharoplasty, non-cosmetic
Breast biopsy
Bronchoscopy with or without biopsy
Carpel tunnel
Cervical biopsies or polypectomies
Circumcision, male
Closed reduction of complete dislocations or fractures
Culdoscopy with or without biopsy
Cyst aspiration
Cystogram
Cystoscopy with or without retrograde pyelogram
Digit amputation
D&C, diagnostic and therapeutic
Dorsal split of prepuce
Esophageal dilation
EUA (examination under anesthesia)
Excision of soft tissue lesions (nevus, verrucus, epithelioma, scar revision)
Fiberoptic endoscopy with or without biopsy
Foreign body removal
Frenulotomy of tongue
Full bone impacted teeth
Ganglionectomy
Gastroscopy with or without biopsy
Herniorrhaphy (up to age 14)
Hydrocelectomy
Hymenectomy
Hysterosalpingography
I&D (incision and drainage of superficial lesions)
Injection of joint, tendon or ligament
IUD insertion and removal, if anesthesia necessary
Kidney needle biopsy
Laceration suture of skin and tendons
Laparoscopy with or without tubal ligation
Laryngoscopy with or without biopsy
Lipoma removal
Liver needle biopsy
Lumbar puncture
Mammoplasty, non-cosmetic
Meatotomy
Minor eyelid procedures
Minor rectal surgery (not under spinal)
Morton's neuroma
Muscle biopsy
Myringotomy
Nasal fracture reduction, open and closed
Nasal Polypectomy
Nerve blocks
Node biopsy (superficial)
Otoplasty, non-cosmetic
Otoscopy with or without biopsy

Pin and screw removals
Proctosigmoidoscopy with or without biopsy
Skin biopsy
Skin graft (small)
Submucus resection of nasal septum
Synovial cyst removal
Tear duct probing
Thoracentesis for fluid aspiration
Trigger finger
Triple upper endoscopy
Urethral dilation
Varicocelectomy
Vasectomy
Vein sclerosing injection
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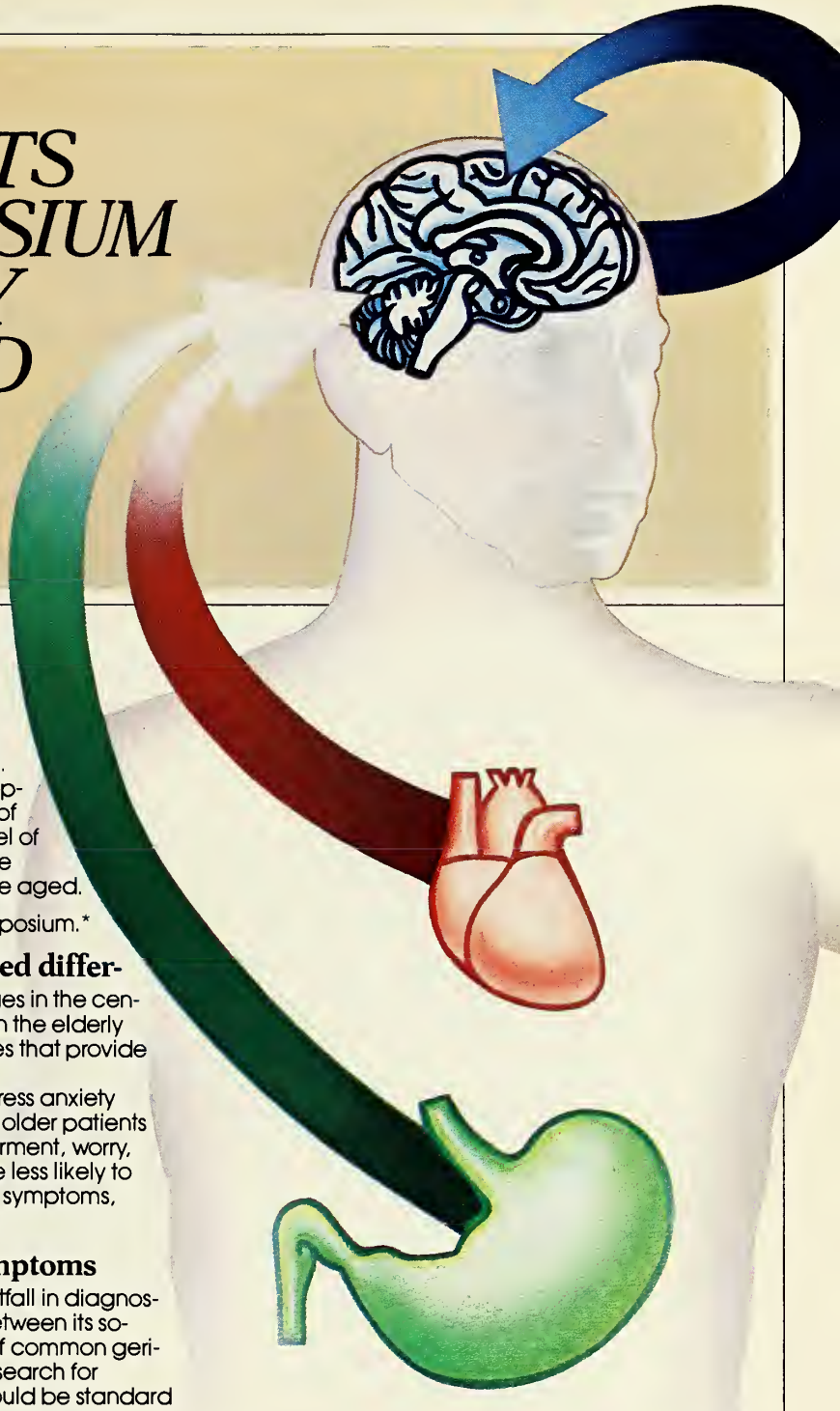
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HIGHLIGHTS OF A SYMPOSIUM ON ANXIETY IN THE AGED

Highlights of diagnosis and treatment



Despite a consensus that significant anxiety is a frequent problem in the aged, surprisingly little substantial basic or clinical research has been undertaken in this area. For that reason, Roche Laboratories in cooperation with the Department of Psychiatry of the University of Arizona, convened a panel of nationally recognized authorities to explore medically relevant aspects of anxiety in the aged.

Here are some of the highlights of that symposium.*

Anxiety experienced and expressed differently in the aged. Age-related changes in the central nervous system may increase anxiety in the elderly who often find themselves in circumstances that provide a great deal to be anxious about.

Whereas younger people usually express anxiety through intricate conversion mechanisms, older patients tend to display overt symptoms—bewilderment, worry, fear, even panic. In addition, the aged are less likely to report an illness or acknowledge physical symptoms, which can lead to difficulties in diagnosis.

The diagnostic dilemma: are symptoms psychosomatic or organic? One pitfall in diagnosing anxiety in the elderly is the similarity between its somatic manifestations and the symptoms of common geriatric illnesses. For that reason, a thorough search for remediable organic causes of anxiety should be standard procedure. The origin of anxiety may be as simple as nutritional anemia, ear wax deafness or vision-impairing cataracts—or anxiety may be a symptom of chronic organic brain syndrome or other physical disorders.

Developing realistic treatment goals for elderly patients. When establishing treatment goals, physicians may take into consideration the patient's personality, life circumstances, duration and intensity of symptoms—and the expected outcome of treatment. Then a definite plan of action is established which may involve psychological intervention, environmental manipulation, pharmacotherapy and/or relaxation techniques. Once the methods and goals of treatment are decided, a follow-up session should be arranged to monitor and assess the results of therapy.

*A symposium in Tucson, Arizona, November 16-17, 1977, sponsored by the Department of Psychiatry, University of Arizona College of Medicine and the Professional Services Department of Roche Laboratories, Division of Hoffmann-La Roche Inc.

Clinics for Crippled Children Listed for August

Thirty-eight clinics for Illinois' physically handicapped children have been scheduled for August by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 25 general clinics, 11 cardiac clinics, one for children with neurological problems and one for myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

3 Peoria Myelodysplasia—St. Francis Medical Center
4 Maryville—Oliver C. Anderson Hospital
4 Park Ridge Cardiac—AM—Lutheran General Hospital
4 Park Ridge General—PM—Lutheran General Hospital
4 Wheaton General—Marianjoy Rehab. Hosp.
5 Hinsdale—Hinsdale Sanitarium
6 Springfield General—St. John's Hospital
6 Anna—Union County Hospital
6 Lake County Cardiac—Victory Mem. Hosp.
7 Division Cardiac—St. James Hosp.
10 Peoria Cardiac—St. Francis Medical Center
10 Belleville—Belleville Memorial Hospital
10 Chicago Heights Cardiac—St. James Hosp.
11 East St. Louis—Community Hospital
11 Peoria—St. Francis Medical Center
12 Rockford—St. Anthony Hospital
12 Champaign-Urbana—McKinley Health Service Center
12 Chicago Heights General—St. James Hosp.
12 Joliet—St. Joseph's Hospital
13 Aurora Cardiac—Mercy Center for Health Care Services
13 Kankakee General—St. Mary's Hospital
17 Maywood—(Orth/Ped/Neuro)—Loyola Medical Center
18 Rock Island Area General—Moline Public Hospital
19 Springfield Ped-Neuro—St. John's Hosp.
19 Aurora General—Sherman Hospital
20 Rockford—Rockford Memorial Hospital
20 Bloomington—Mennonite Hospital
20 Elmhurst Cardiac—Memorial Hospital of DuPage County
21 Kankakee Cardiac—St. Mary's Hospital
24 Peoria Cardiac—St. Francis Med. Center
24 Chicago Heights Cardiac—St. James Hosp.
24 Maywood—(Orth/Ped)—Loyola Medical Center
26 Chicago Heights General—St. James Hosp.
26 Elgin General—Sherman Hospital
27 Litchfield—St. Francis Hospital
28 Evanston—St. Francis Hospital
31 Peoria Cardiac—St. Francis Medical Center
31 Maywood—(Orth)—Loyola Medical Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

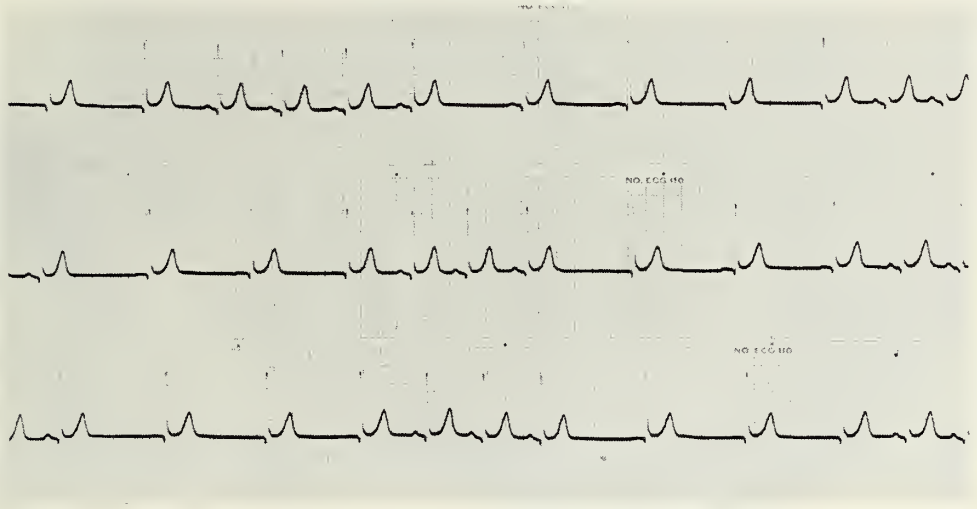
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Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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EKG of the Month

This patient is a seventy-two year old man who was in good health until two years ago. At that time, he developed congestive heart failure. He responded to digoxin although no etiology for the heart failure was found. Several months ago, premature ventricular beats were found. Quinidine sulfate was used to treat these extrasystoles. For the past few days he has been nauseated and has lost his appetite. His physical examination showed normal lung findings and normal blood pressure. His pulse was irregular. A long lead II rhythm strip was obtained and is shown.



Questions:

1. The ECG shows:
- a. Short bursts of paroxysmal atrial tachycardia.
- b. Extreme sinus arrhythmia
- c. Junctional rhythm functioning as an escape rhythm.
- d. Sinus arrest or high grade sino-atrial block.
- e. All of the above

2. Management of this patient could include:
- a. Placement of a demand ventricular pacemaker.
- b. ECG monitoring in the hospital.
- c. Discontinuation of digoxin and quinidine.
- d. Measurement of serum digoxin level.
- e. All of the above.

(Continued on page 63)

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CIBA 165

potassium chloride slow-release tablets 8 mEq

Please turn page for brief prescribing information.

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Slow-K is a sugar-coated (not enteric-coated) tablet containing 600 mg potassium chloride (equivalent to 8 mEq) in a wax matrix. This formulation is intended to provide a controlled release of potassium from the matrix to minimize the likelihood of producing high localized concentrations of potassium within the gastrointestinal tract.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy, and certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and, if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
In patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (eg, spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the G. I. tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS
Hyperkalemia: In patients with impaired mechanisms for excreting potassium, administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium intravenously but may also occur when given orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. Use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium-Sparing Diuretics: Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (eg, spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal lesions: Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (40-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains less than one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic acidosis: Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
Potassium depletion is ordinarily diagnosed by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. Treatment of potassium depletion, particularly in presence of cardiac disease, renal disease, or acidosis, requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, electrocardiogram, and clinical status of patient.

ADVERSE REACTIONS
Most common to oral potassium salts: nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by diluting the preparation further, taking the dose with meals, or reducing the dose.

One of the most severe adverse effects is hyperkalemia (see Contraindications and Warnings). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration and perforation (see Contraindications and Warnings); other factors known to be associated with such conditions were present in many of these patients. Skin rash has been reported rarely.

DOSAGE AND ADMINISTRATION
Usual dietary intake of potassium by the average adult is 40 to 80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires loss of 200 or more mEq of potassium from the total body store.

Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for prevention of hypokalemia to 40-100 mEq per day or more for treatment of potassium depletion.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed or chewed.

HOW SUPPLIED
Tablets (pale orange, sugar-coated), each containing 600 mg (8 mEq) potassium chloride; bottles of 100, 1000 and Accu-Pak® blister units of 100.
C78-23 (4/78)

Consult complete product literature before prescribing. 128-6090-A

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C I B A

OBITUARIES

***Fahrner, F.R.,** Joliet, died June 12, at the age of 56. Dr. Fahrner was a 1953 graduate of St. Louis University Medical School.

***Krasner, Leonard,** Waukegan, died June 7, at the age of 73. Dr. Krasner was a 1936 graduate of the Universitat Tubingen Baden in Wurttemburg, Germany.

****Maloney, J.H.,** Rockford, died June 8, at the age of 95. Dr. Maloney was a 1913 graduate of the Hahaman Medical School.

***Marzano, Rose Mary,** Chicago, died May 31, at the age of 79. Dr. Marzano was a 1942 graduate of the Chicago Medical School.

***Ocasek, Miles Frank,** Villa Park, died June 3, at the age of 71. Dr. Ocasek was a graduate of the Chicago Medical School.

Stamler, Maurice, Chicago, died at the age of 72. Dr. Stamler was a 1933 graduate of the University of Illinois School of Medicine. ◀

* Indicates ISMS member
**Indicates ISMS member of the fifty year club

Familial Ovarian Cancer Registry

There are increasing reports of ovarian cancer occurring in two (2) or more family members. The Familial Ovarian Cancer Registry will evaluate this increase to obtain information for genetic counseling to family members. Case accrual will evaluate:

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- the study of environmental, geographical and racial factors
- genetic counseling.

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Highland Park Hospital has identified one of the few remaining areas in Chicago that holds definite promise for the physician who wants to ensure a successful practice in the 80's.

The area is the town of Buffalo Grove and its neighboring communities. Planners expect the population there to increase by 40% in the next ten years. The average household income is $24,000 and growing. The overwhelming majority of residents are covered by private insurance. By any index, it is a growth market with a great promise for financial viability.

An exceptional offering. Highland Park Hospital is completing a $3 million medical office complex at the hub of this growth area. Called The Grove Professional Center, the 30,000 square foot facility will provide suites for up to twenty physicians, supported by radiology, laboratory services and a pharmacy.

Charter tenants receive three months free rent, guaranteed below-market rental rates for three years, paid utilities, a generous suite completion allowance, and a guarantee of no hidden costs. The hospital is also committed to a major marketing program to help physicians build their practice as quickly as possible.

Affiliate with respected peers. As a member of the Highland Park Hospital medical staff, you'll associate with a group of physicians that *U.S. News and World Report* called "among the most high powered in the metropolitan (Chicago) area." And you'll work at a hospital with an outstanding reputation for superior care, technical sophistication and a gracious environment.

How will your practice fare in the 80's? Physicians who want to understand and meet the challenges of the 80's are invited to attend one of two seminars sponsored by the hospital. Entitled, "How to Strengthen the Financial Return of Your Medical Practice," they will be conducted by a leading consultant on medical practice management. Opportunities at the Grove Professional Center will also be reviewed. The July 11 seminar will be from 8:00 a.m. to 2:00 p.m. and include a luncheon at the Charlie Club in Palatine; the July 22 seminar will be from 5:00 p.m. to 10:00 p.m. at The Park Hyatt in Chicago. Cocktails and hors d'oeuvres. Advanced registration is required; the fee for materials is $10.00. Call (312) 432-8000, extension 3328 to register.

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The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,
Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Michael Fine, M.D., an assistant professor of radiology, and Timothy B. Scarff, M.D., an associate professor of neurosurgery, from the Loyola University Medical Center, Maywood.

This twenty-one year old male had pain and sensory loss in the distribution of the left S_2 nerve root. The myelogram shows a questionable defect of this root (arrow, Figure 4). What would you do next?



Figure 1
Metrizamide myelogram AP view—Lumbar spine

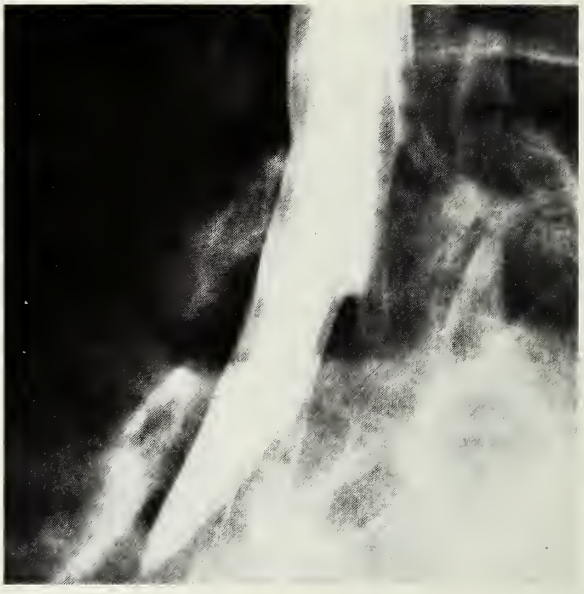


Figure 3
Right oblique view

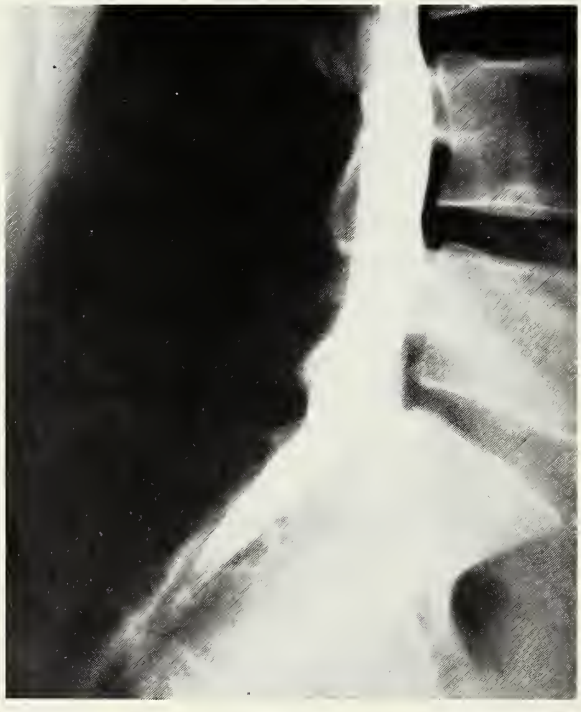


Figure 2
Lateral view

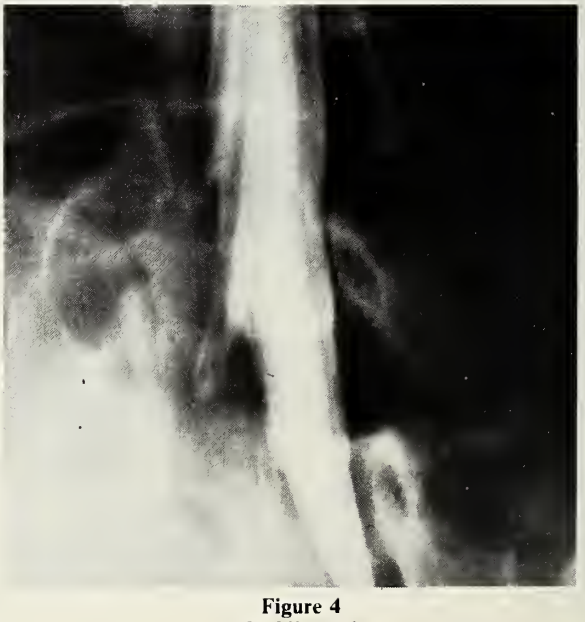


Figure 4
Left oblique view

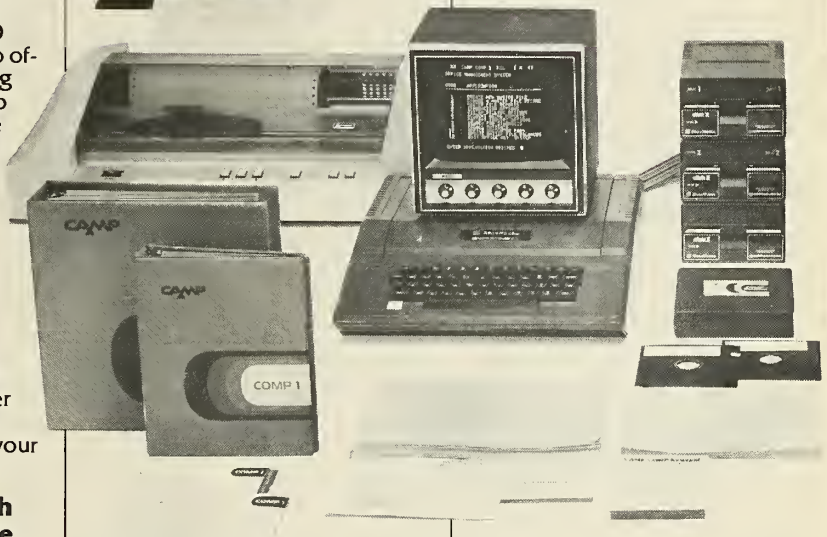
Options

(1) Refer for surgery; (2) Repeat myelogram with Pantopaque; (3) Epidural venogram; (4) Computed tomography; (5) Follow patient clinically.

(Continued on page 64)

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Illinois Housestaff News

New Officers Named

By David Palmer, M.D., Secretary/Editor

On May 7, 1981, the Resident Physicians Section of Illinois convened at the Illinois State Medical Society headquarters in Chicago, and elected the 1981-82 Governing Council. The Council members include:

Chairman: Elected chairman for a second term, Larry Gratkins, M.D., a Northwestern University graduate, has served on several ISMS/RPS councils and leadership seminars, is an AMA/RPS delegate, has authored several OB/GYN publications, and has published in the ISMS journal. Chief resident in OB/GYN at Northwestern University Hospitals, Chicago, and a junior fellow in ACOG, Larry will enter the Air Force following his residency training.

Vice Chairman: A former secretary of AMA/RPS, Brad Epstein, M.D., is a delegate to the AMA/RPS, has served on various councils, and held office in the ISMS/SBS. He received his M.D. from the University of Chicago, is a junior fellow of ACOG, and will be a PGY-2 in OB/GYN at Rush-Presbyterian St. Luke's Hospital, Chicago. His immediate post-residency plans include entrance into the Air Force medical system.

Secretary/Editor: David Palmer, M.D., is an AMA/RPS delegate, has been involved on ISMS/RPS councils, and has authored several publications. He earned his M.D. from the University of Chicago, and completed his medical internship at Michael Reese Hospital, Chicago. David will continue his residency training at the University of Illinois Eye and Ear Infirmary in Ophthalmology and plans a clinical practice with university affiliation.

Delegate: Formerly serving in the Illinois and AMA House of Delegates, William Golden, M.D., is a graduate of the Baylor College of Medicine, and will begin his third year of residency at Rush-Presbyterian St. Luke's Hospital.

As the national AMA convention in Chicago echoes in our minds, the challenge of a new year is upon the AMA/RPS and organized medicine in general. Current statistics indicate that there are over 17,000 AMA/RPS members, of which 1200 alone are from Illinois. Although the percentage of residents who are AMA members has steadily increased since the founding of RPS in 1973, participation by most, if not all housestaff, is necessary to help mold a health care system in which we will professionally practice.

A recent survey by the California Medical Association indicated that fewer than 31% of California physicians—especially the younger M.D.s—have a "very favorable" regard toward professional societies, primarily because of apparent mismanagement of important issues. As education was highly applauded, the other "most important medical society functions" of "membership services," "professionalism," and "political role" ranked less favorably. Finally, the respondents gave the medical society low scores on the most significantly-rated issues facing the medical profession—combating government control, medicine's public image, health care costs, and malpractice. Many state societies may be similarly faulted, but a state society can function favorably only by membership input and constructive criticism resulting in reform. A poor attitude in professional societies may be a reflection of both the society itself and its highly critical, but apathetic, current and potential membership.

The newly-elected ISMS/RPS Governing Council of Illinois is, and will be, aware of discrepancy in membership expectation and society performance. Mutual interaction by the membership and board *can* result in a truly effective organization answering group and individual needs. Last May the ISMS/RPS Governing Council sent out a letter to all resident members of the Illinois State Medical Society, which invited them to help make the voice of the resident heard more strongly in organized medicine by participating in the many committees and councils of the ISMS where policy is developed. In addition, the Constitution and Bylaws of the ISMS/RPS provide that the Governing Council have a representative from each hospital program in the state. We need participation. We need dialogue. We need you! If you have any questions or concerns regarding the formulation or drafting of policy decisions which will directly or indirectly affect you in your medical career, or if you have ideas, suggestions, interested friends, etc., then please contact us at the ISMS, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603, and get involved in *your* future. ◀

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IMJ
Illinois Medical Journal
Volume 160, No. 1, July 1981

Syme's Two Stage Amputation In Diabetic Dysvascular Disease

By Michael S. Pinzur, M.D., Chris Jordan, M.D.
and Nasim A. Rana, M.D./Chicago

Diabetic dysvascular disease often results in tissue gangrene and a below or above-knee amputation. The energy expenditure in such amputees required for ambulation with a prosthesis, is often so great as to markedly diminish their ambulatory ability. One hundred and nine lower extremity amputations were performed in a one year period at the Chicago Lakeside Veteran's Hospital. Using Doppler arterial pressure measurements to evaluate amputation level, nine of the patients had Syme's Two Stage ankle disarticulations with only one failure.

Diabetic dysvascular disease is a common and disabling problem. In the past, development of a foot ulcer in the adult diabetic patient frequently led to prolonged disability and often to proximal level amputation. The vascular supply to the foot of the dysvascular diabetic is often so poor that these patients do not have the capacity to heal the ulcers. Without appropriate local and systemic care, the ulcers can become secondarily infected, and progress to tissue gangrene. In the past, many patients succumbed to sepsis or survived with a proximal level amputation below or above the knee.

Data from the Gait Analysis Laboratory at Rancho Los Amigos Hospital has shown increased energy expenditure and decreased walking ability with proximal level amputation.[1]

The diabetic dysvascular below or above-knee amputee may not only require increased energy expenditure to walk, but may also require a prolonged training period with the prosthesis in order to achieve maximum ambulatory status. Many of these patients are 60 or more years of age, and physiologically older than that. They often do not have the energy reserve to ambulate with a prosthesis. Many are only able to use the prosthesis for very short distances and the proximal level amputee may frequently be confined to a wheelchair existence. Amputation at the ankle joint (Syme's Amputation) or foot level requires

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NASIM AHMAD RANA, M.D., is a board certified orthopedic surgeon affiliated with Northwestern Memorial Hospital in Chicago. A fellow of the Royal College of Surgeons of Canada, Dr. Rana serves as an associate professor of clinical orthopaedics for the Northwestern University Medical School. He is also chief of the orthopedic service for the Veteran's Administration Research Hospital.



Figure 1
This patient had a large plantar ulcer overlying a bony prominence from a rigid pes planus. He had severe pain and drainage which was resistant to numerous forms of local and orthotic treatment.



Figure 2
The incision (patient from figure 1) had to be modified to accommodate the large plantar ulcer. The dorsal flap is correspondingly longer.

only mild increases in energy expenditure and minimal prosthetic training.

Most diabetic foot ulcers can be successfully treated without resorting to amputation. Patient education, local wound care, and judicious orthotic treatment can usually provide an environment conducive to healing.[2] When amputation is required, it can often be successfully performed at distal levels with a high success rate.

Surgeons have generally avoided distal level amputation in the dysvascular patient for two reasons. Evaluation of amputation level was based solely on clinical judgement without objective indices. As a result, aggressive amputation surgeons experienced an unacceptably high failure rate. A high failure rate was especially undesirable in these patients, whose poor general health made them poor surgical risks. To avoid failure and repeat surgery, these patients were treated with "safe" proximal level amputation.

Doppler arterial pressure measurement has enabled a simple and usually predictable index of a dysvascular patient's capacity to heal an ulcer, a surgical procedure, or an amputation at a given level in the extremity.[3-6] This measurement may be easily obtained at bedside. An absolute Doppler pressure measurement of 70 mmHg,[6] or a ratio between local Doppler arterial and brachial arterial pressure of 0.45 or greater, leads to a predictable success rate for healing a surgical procedure in well over 90% of patients.[5,7] This ratio has been termed the ischemic index, and has been used with increasing success in many centers.

Using the treatment program developed at Walter Reed Hospital[8] and modified at Rancho Los Amigos Hospital,[5,7] we have performed nine Syme's Two Stage Amputations (ankle disarticulation with secondary malleolar excision) with only one failure. Previously, all of these patients would have been treated with below-knee amputations.



Figure 3
First stage wound closure. The "dog ears" will be excised with malleolar excision at the second stage.



Figure 4
The leg at one year post amputation (patient from figure 1) shows a healthy plantar flap. The ulcer seen in this photo developed recently and is presently being treated as an outpatient with local wound care and prosthetic modification.

Materials and Methods

In the course of one year, 109 lower extremity amputations were performed for dysvascular disease at the Chicago Lakeside Veteran's Hospital (Table 1). All were evaluated pre-operatively with Doppler arterial pressure measurements. Nine patients (8.3%) were found to fit the criteria for Syme's Two Stage Amputation as proposed by Wagner.[5,7] In none of these patients could the foot be salvaged with local surgery or more distal level amputation.

Local wound care consisted of twice daily dressing changes with providone-iodine saturated gauze bandages. The dressings were removed dry; this was the only form of debridement. The limbs were kept flat in bed excepting meals and toilet. Parenteral antibiotics were administered only in the presence of cellulitis. Cephalothin one gram every six hours intravenously or Cefazolin one gram every eight hours intramuscularly were administered until the cellulitis dissipated (in most cases, this occurred within forty-eight hours). The patients were then maintained on Cephalexin, 500mg every six hours orally until surgery. Surgery was performed only after tissue demarcation was well established. All patients had been evaluated by the vascular surgery service for arterial reconstruction. Those patients who were candidates for arterial reconstruction had their reconstruction performed initially and amputation at a later date. It was felt that this order would give the amputation site the greatest opportunity to heal.

All patients fit the criteria for Syme's Two Stage amputation as described by Wagner: (1) patient must be a potential prosthetic user; (2) heel pad must be free of open lesions; (3) Doppler arterial pressure at the ankle must be at least 70mm.Hg; (4) ratio of ankle Doppler arterial pressure to brachial arterial pressure (ischemic index) must be greater than 0.45; (5) there should be no gross pus at the amputation site; (6) there should be no ascending lymphangitis (cellulitis); (7) there should be no gas in the tissues above the amputation site by palpation or by roentgenogram and (8) intra-operative bleeding should occur in the skin flaps within three minutes after tourniquet release.[7]

Surgery was performed in two stages, as described by Spittler, *et. al.*[8] Ankle disarticulation was performed as the first stage, followed six weeks later with malleolar excision. A rigid plaster dressing was applied two or three days postoperatively and a short leg walking cast was

Table 1
Low extremity amputations performed for dysvascular patients during the year 1978

Amputation Level	Diabetes	Other	Total	Percent
Above-Knee	16	8	24	22.0
Below-Knee	22	15	37	33.9
Syme (Ankle Disarticulation)	9	0	9	8.3
Lissfranc (Tarso-Metatarsal Joint)	2	0	2	1.9
Ray Resection	8	0	8	7.3
Toes (Single or Multiple)	24	5	29	26.6
Total				
Number	81	28	109	
Per Cent	74.3	25.7	100	

applied two to three days following malleolar excision (Figure 6). Definitive prosthetic fitting with a standard Syme's amputation prosthesis was performed four weeks following the second stage.

Results

Of the nine Syme's Two Stage Amputations performed, seven healed uneventually and were fitted with a standard Syme's amputation prosthesis four weeks following the second stage surgery. All seven patients have returned to their pre-operative status as community walkers. One patient had an apparent early failure, but was successful after several minor surgical debridements (Figures 1 through 4). He was subsequently fitted for a standard Syme's Amputation Prosthesis and has returned to work as a salesman. The one failure was salvaged to a below-knee level and is presently a household walker with a standard patellar-tendon bearing below-knee prosthesis.

Discussion

Of nine patients treated in this series, only one was a failure and had to be revised to a below-knee level. This patient had osteomyelitis of the midfoot with open wounds just distal to the dorsal skin incision. At surgery, he was found to have purulent drainage from the common extensor tendon sheath. This was thoroughly debrided and irrigated at surgery. He did not develop any local or systemic signs of infection post-operatively; the wound simply failed to heal. Local wound care was unsuccessful and the patient was revised to a below-knee level.

One patient was successful, but only after prolonged local wound care. Pre-operatively he had a large plantar ulcer which compromised the plantar flap. To accommodate this ulcer, the dorsal flap was made longer (Figures 1 and 2). On the ninth post-operative day, the wound began to show signs of infection/failure with sero-purulent drainage and mild cellulitis. The wound was



Figure 5a



Figure 5b

This patient shows the typical pattern of gangrene of the patients in this series.



Figure 6
A short-leg walking cast is applied two or three days post-op second stage amputation. It is used as an interim fitting until permanent prosthetic fitting can be accomplished (usually four weeks post-op stage two).

opened and packed with Providone-Iodine soaked gauze bandages. *Pseudomonas aeruginosa* was subsequently cultured from the wound. The wound was dressed daily. Three surgical debridements were performed before the wound was closed. Malleolar excision was performed at the second surgical debridement. The wound healed and the patient was fitted with a standard Syme's Amputation Prosthesis. He returned to work and recently developed a small plantar ulcer (Figure 4) which is successfully being treated without interruption in prosthetic wear, with local wound care and prosthetic adjustment.

Summary

During a one year period, nine diabetic dysvascular patients with gangrene of the forefoot were treated with Syme's Two Stage Amputation. Previously, these patients would probably have been treated with below-knee amputation. Eight have returned to community walker status following successful surgery. The one failure was revised to a below-knee level.



Figure 7
Typical healed wound four weeks after second stage procedure.

Distal surgery and amputation can be successfully performed in the diabetic dysvascular patient. The Doppler technique has become an invaluable tool in assessment of the dysvascular patient. Using the treatment plan described, distal level amputation can be performed in the diabetic dysvascular patient using simple and readily available techniques. ◀

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Rheumatology Rounds

L. F. Layfer and J. V. Jones, Contributing Co-Editors

Rickets Due To Chronic Anticonvulsant Therapy

By Jeno I. Sebes, M.D. and Bruce M. Rothschild, M.D./Tennessee

A case of rickets is described in a patient who had been on anticonvulsant medication since infancy. The correlation between chronic anticonvulsant therapy and disturbance of calcium metabolism is discussed. It is concluded that chronic anticonvulsant use alters the metabolism of cholecalciferol (vitamin D_3) producing less active antirachitic compounds leading to vitamin D deficiency.

Rickets, as a result of chronic anticonvulsant therapy, was first suggested in epileptic children in Germany in 1968.[1] A study of epileptic patients revealed a strong correlation between biochemical indices of osteomalacia and the dose and duration of anticonvulsant medication administered to these patients.[2] Unfortunately, little attention has been given to this relationship in the recent literature. It is the purpose of this report to call attention to this entity by presenting our experience with a recent case.

Case Report

A 16-year-old white male was admitted for control of seizures and recurrent aspiration pneumonia. Seizures were partially controlled on 250mg primidone b.i.d. and 120mg phenobarbital per day. He was mentally retarded with seizures since birth and observed features included a warty papillomatous lesion occupying the right side of his face, which on histologic examination revealed sebaceous gland hyperplasia. This symptom complex, in the presence of a dermoid of his right eye, lead to diagnosis of epidermoid nevus of Jadassohn.[3] Seizure frequency had increased and patient was admitted for evaluation. Because of severe mental retardation, he had seldom been outside his crib. Physical examination revealed a severely retarded white male with atrophic limbs, multiple contractures, thin narrow pelvis, pigeon chest and rachitic rosary. Adenoma sebaceum occupied the right side of the face and fundiscopic examination of the right eye revealed a small mass, felt to be a dermoid. Radiographs revealed delayed skeletal maturation, fraying and expansion of metaphyses of long bones (Figure 1) with irregularity, poor ossification and minimal slippage of the proximal humeral epiphysis. The trabecular pattern in the metaphyses of long bones was markedly coarsened (Figure 2). The

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Figure 1
Rachitic changes of the wrist with metaphyseal widening and fraying.



Figure 2
Widening of the humeral metaphysis with slight slippage of the humeral head. Note the course trabecular pattern in the proximal humeral metaphysis and the widening and slight cupping of the first anterior rib (arrow).

ribs showed flaring of the costochondral junctions corresponding to the rachitic rosary found on physical examination. Laboratory examination revealed 11,700 white blood cells, 70% polymorphonuclear leukocytes, 30% lymphocytes, calcium 6.9 mg% (Normal Range: 8.4-10.5 mg%), albumin 2.9 grams %, alkaline phosphatase 600 U/L (Normal Range: 10-68 U/L), and phosphate 2.4 mg% (Normal Range: 2.2-4.5 mg%). Hematocrit was 36% with a serum iron of 30 mg% and an iron binding capacity of 210 mg%. Serum glucose, potassium, magnesium, spinal fluid glucose, cell count, protein, and opening pressure were all negative or normal. Urine chromatography did not reveal the aminoaciduria of Fanconi syndrome. Anemia responded to iron therapy. Seizures responded to calcium and vitamin D therapy.

Discussion

The pathogenesis of rickets in children on anticonvulsant drugs is based on evidence that the metabolism of vitamin D is markedly altered by these drugs.[4,5] The main source of vitamin D in humans is vitamin D_3. In the liver vitamin D_3 is converted to 25-hydroxy-cholecalciferol (25-HCC) which is the initial active metabolite of vitamin D_3 with antirachitic activity.[6,7] 25-HCC is further metabolized in the kidney into 1,25-dihydroxycalceferol with much greater (100 fold),[8] antirachitic activity.[8-10] It is well established that the induction of hepatic P-450 microsomal enzyme activity with diphenylhydantoin and phenobarbital results in increased catabolism of several steroid hormones with increased excretion of their metabolites.[11] The effect is dose related and results in decreased biological activity of exogenously administered steroids.[12] Since vitamin D and its active metabolites are structurally similar to steroid compounds, it can be anticipated that they would also undergo enhanced catabolism when the hepatic P-450 enzyme is activated. These findings have been confirmed in patients on long-term diphenylhydantoin[13] and phenobarbital[14] therapy by demonstrating decreased plasma half-life of tritiated vitamin D_3 and increased amount of metabolites with little or no antirachitic activity, compared with 25-HCC. Response to ultraviolet irradiation with rapid healing of diphenylhydantoin-induced rickets is consistent with its effect in raising levels of 25-HCC.[15] Direct administration of 25-HCC has the

same effect[16]. It is interesting that rickets can complicate neonatal hepatitis, probably on the basis of decreased synthesis of 25-HCC.[17] In view of the observation of Anast,[18] Stamp[15] and Lifshitz and Marclaren,[19] limited sun exposure in our patient is probably a contributory factor. Several laboratory studies of epileptics on long term anticonvulsant therapy revealed a significantly increased incidence of hypocalcemia, elevated alkaline phosphatase and decreased 25-HCC in 19-30% of the cases.[2,5,13,19,20] Although the liver plays an important part in the metabolism of vitamin D, one-hydroxylation in the kidney produces the metabolite with the greater capacity for mobilization of calcium from bone.[7] Hepatic 24-hydroxylation, which is stimulated by anticonvulsants, yields a compound with much reduced activity.[7] An alteration in the level of serum transport protein for vitamin D[21] should also be considered in view of the effect of androgens and prednisone on levels of thyroid binding globulin.[22] Another possible mode by which anticonvulsants influence calcium metabolism is the production of a specific absorption defect in the intestinal mucosa.[23] This mechanism is supported by investigators on the basis of studies demonstrating defective xylose absorption from the intestine in patients receiving diphenylhydantoin,[24] *and a decreased calcium transport* in organ culture on challange with anticonvulsants.[25,26] Additionally, diphenylhydantoin directly inhibits 25-HCC induced bone resorption.[27]

The recognition of the classical radiographic manifestations of rickets is important from the standpoint of management and prevention of anticonvulsant osteomalacia. Unfortunately, in most cases, it is impossible to discontinue the anticonvulsant medication in patients with various seizure disorders. It is, however, quite common to obtain excellent clinical recovery and complete reversal of the changes of osteomalacia after institution of supplemental therapy with vitamin D and calcium, and increasing exposure to ultraviolet light.

References

A complete set of references for "Rickets and Anticonvulsant Therapy," may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago 60603.

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IDPA Implements MMIS

The Illinois Department of Public Aid has developed and completed the Medicaid Management Information System for implementation in Illinois. MMIS is a new computer system for billing which is intended to monitor all IDPA claims and payments.

IDPA is activating the MMIS program in St. Clair County during the month of July. Physicians in Cook County will be required to use the system as of August 15, and implementation for the balance of the state will be completed on September 15. These dates are expected to remain in effect. Any change in these dates will be communicated to you.

ISMS has received many inquiries and questions about the MMIS program from physicians who find many of the new regulations and requirements unclear and confusing. In an effort to provide the membership with a clearer picture about the MMIS program, ISMS is publishing these next few pages to assist members converting to this program.

IDPA has mailed packets of material to all Illinois physicians who participate in the Medicaid program. These materials should include a Physician Enrollment Application, schedules of local seminars for physicians and other explanatory information. If your office has not received the MMIS materials from IDPA, please contact IDPA using the toll free number in Springfield 800-252-8937 or write to:

Illinois Department of Public Aid
Provider Participation Unit
P.O. Box 4034
Springfield, Illinois 62708.

One item of singular importance is the *Physician Enrollment Application* which must be completed and returned to IDPA if a physician wishes to continue to bill IDPA after MMIS is implemented in his or her part of the state. By completing this form, physicians will ensure their continued participation in the MMIS program.

Physicians who do not re-enroll by completing the Physician Enrollment Application prior to implementation of MMIS in their part of the state will be unable to bill IDPA until this form is completed.

ISMS strongly suggests that office staff personnel attend the seminars sponsored by IDPA which will help to explain the mechanics of the MMIS system. A list of seminars was included in the enrollment packet. ISMS also strongly recommends that physicians who use computer billing services contact those services **immediately** to allow time to prepare for conversion to the new system.

ISMS will monitor the implementation of the MMIS system very closely and will attempt to aid physicians seeking answers to questions about the new system. If your questions cannot be satisfactorily resolved in discussions with IDPA's Bureau of Provider Services, please feel free to contact ISMS at (312) 782-1654. (Ask for the Division of Field Services.)

ILLINOIS DEPARTMENT OF PUBLIC AID
MEDICAID MANAGEMENT INFORMATION SYSTEM

PHYSICIAN ENROLLMENT APPLICATION

PHYSICIAN INFORMATION

Section I

1. Name Jones (Last) John (First) M Telephone Number () Optional
2. Address 2222 High Street (Street) Anytown (City) IL (State) 60400 (Zip)
3. Primary County of Practice Your County
4. Social Security Number 688000000
5. Physician A.M.A. Number 01699999999
6. State License Number 036099999
7. Medicare Provider Number 123456
8. D.E.A. Number 0000000
9. Do you wish to provide Medichek Screening Services? (X) Yes () No

PAY-TO INFORMATION

Section II

(Postal zip code must be entered for each payee)

1. Primary Payee Information
 A. Name Jones John M
 B. Address 2222 High Street
 Anytown Il 60411
 C. FEIN
 of Clinic () Group Practice () Corporation ()
2. Second Payee Information
 A. Name Medical Service Corp
 B. Address 1111 Friendship Court
 Anytown Il 60400
 C. FEIN 00000000
 of Clinic () Group Practice () Corporation (X)
3. Third Payee Information
 A. Name Jones Clinic
 B. Address 2222 High Street
 Anytown IL 60400
 C. FEIN 00000000
 of Clinic (X) Group Practice () Corporation ()
4. Fourth Payee Information
 A. Name
 B. Address
 C. FEIN
 of Clinic () Group Practice () Corporation ()

MD PRACTICE SPECIALTIES

Section III

List primary specialty first.

1. GP
 FP
 GS
 OBG

Codes are listed on Practice Specialties Sheet attached.

MEDICAID FORMS USAGE

Estimate monthly quantity used.

FORM #	Name	Usage	Form #	Name	Usage
*DPA 1443	Provider Inv.	1000	DPA 1410	Adjustment	100
DPA 2189	Steril. Cons.	0000	DPA 1862	Abort. Cert.	0000
DPA 1409	Pri. Appr. Oth.	100	PH 0600	Medichek Inv.	100
DPA 2239	Pri. Appr. Trn.	0000	DPA 2240	Pri. Appr. Eq.	
DPA 1977	Hysterectomy Info. Acknowledge Receipt				0000

*Do you wish these invoices in continuous feed (X) or snap-out ()

Section IV

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE, ACCURATE, AND COMPLETE:

John M Jones MD — Physician Signature

061581 — Date Signed

FOR IDPA USE ONLY

Section V

PROVIDER TYPE: 10

1. Approved ____ 2. Effective ____ 3. Approved by ____
5. Disapproved ____ 6. Reason ____
7. Location ____ 8. County ____ 9. Old Vendor I.D. ____
10. License Exp. Date ____ 11. Verified by ____ 12. Date ____
13. CUSAS NUMBER 14. Group Ind.
 A. ____ ____
 B. ____ ____
 C. ____ ____
 D. ____ ____

4. COS
 ____ 01
 ____ 06
 ____ 17
 ____ 30
 ____ 45

SAMPLE

Instructions for Completing Physician Enrollment Application

SECTION I *Complete the items in spaces 1 through 9*

The use of punctuation on any part of this form cannot be accommodated. Please do not use periods, commas, dots, dashes or any other punctuation when completing this form. Please refer to the sample application.

SECTION II *Pay To Information*

- A unique aspect of the MMIS system—that differs from the current IDPA system—is the opportunity for physicians to designate the payment for medical services to more than a single address.
- Many Illinois physicians are affiliated with clinics, group practices and other corporations for payment of services. Conversely, many physicians in Illinois operate only one office and receive all reimbursements at that address.
- The MMIS system will now accommodate both situations through its multiple payee feature. For example, a physician with one office will only be concerned with completing category number 1 in Section II. However, physicians who are affiliated with clinics, group practices and other corporations can now complete categories 1 through 4, as appropriate, and payments by IDPA will be made to the designated address. (Box Number 33 on the Claim Form is described on the Claim Form explanation accompanying this article.)
- The multiple payee feature of the MMIS system is intended to reduce accounting paperwork when physicians have contract or salary arrangements with a clinic, group practice, hospital or other corporation for payment of services to IDPA patients.
- For IRS purposes, all payments directed to a designated Federal Employer Identification Number (FEIN) will appear on IRS 1099 for that particular corporation or clinic.
- If the FEIN number is not designated for alternate payees on the Physician Enrollment Application IDPA *will not* process the Physician Enrollment Application.
- There is contained in the packet of information sent to you by IDPA, material which *must* be completed for designating one or more alternate payees.
- If you choose to elect the alternate payee option(s), you *must* complete IDPA Forms—2305, 2306, 2307 and 2308—that are included in the packet of enrollment materials.
- Notify the Provider Participation Unit in writing to report any changes or corrections to Section II of the Physician Enrollment Application.

 Illinois Department of Public Aid
 Provider Participation Unit
 P.O. Box 4034
 Springfield, Illinois 62708

SECTION III

- Please refer to the Practice Specialty List that accompanies this article and provide the appropriate specialty abbreviation in the space(s) provided.
- Complete this section with the types and amounts of blank forms you will use. IDPA will mail blank forms to you. Blank forms will *no longer* be obtainable from your local Public Aid office.
- The claim form (DPA 2360) is only available from IDPA in continuous feed form.

Specialty Codes For Physicians
(For Use In Completion Of Enrollment Application)

ADL ADOLESCENT MEDICINE
AI ALLERGY AND IMMUNOLOGY
AM AEROSPACE MEDICINE
A ALLERGY
AN ANESTHESIOLOGY
BLB BLOODBANKING
BE BRONCHO-ESOPHAGOLOGY
CD CARDIOVASCULAR DISEASES
D DERMATOLOGY
DMP DERMATOPATHOLOGY
DIA DIABETES
EM EMERGENCY MEDICINE
END ENDOCRINOLOGY
FP FAMILY PRACTICE
GE GASTROENTEROLOGY
GP GENERAL PRACTICE
GPM GENERAL PREVENTIVE MEDICINE
GER GERIATRICS
GYN GYNECOLOGY
HEM HEMATOLOGY
HYP HYPNOSIS
IG IMMUNOLOGY
ID INFECTIOUS DISEASES
IM INTERNAL MEDICINE
LAR LARYNGOLOGY
LM LEGAL MEDICINE
MFS MAXILLOFACIAL SURGERY
ND NEOPLASTIC DISEASES
NEP NEPHROLOGY
N NEUROLOGY
NPM NEONATAL-PERINATAL MEDICINE
CHN NEUROLOGY, CHILD
NA NEUROPATHOLOGY
NM NUCLEAR MEDICINE
NR NUCLEAR RADIOLOGY
NTR NUTRITION
OBS OBSTETRICS
OBG OBSTETRICS AND GYNECOLOGY
OM OCCUPATIONAL MEDICINE
ON ONCOLOGY
OPH OPHTHALMOLOGY
OT OTOLOGY
OTO OTORHINOLARYNGOLOGY
PTH PATHOLOGY
CLP PATHOLOGY, CLINICAL
FOP PATHOLOGY, FORENSIC
PD PEDIATRICS
PDA PEDIATRIC ALLERGY
PDC PEDIATRIC CARDIOLOGY
PDE PEDIATRIC ENDOCRINOLOGY
PHO PEDIATRIC HEMATOLOGY-ONCOLOGY
PNP PEDIATRIC NEPHROLOGY
PA PHARMACOLOGY, CLINICAL
PM PHYSICAL MEDICINE & REHABILITATION
P PSYCHIATRY
CHP PSYCHIATRY, CHILD
PYA PSYCHOANALYSIS
PYM PSYCHOSOMATIC MEDICINE
PH PUBLIC HEALTH
PUD PULMONARY DISEASES
R RADIOLOGY
DR RADIOLOGY, DIAGNOSTIC
PDR RADIOLOGY, PEDIATRIC
TR RADIOLOGY, THERAPEUTIC
RHU RHEUMATOLOGY
RHI RHINOLOGY
RIP RADIOSOTOPIC PATHOLOGY
ABS SURGERY, ABDOMINAL
CDS SURGERY, COLON & RECTAL
GS SURGERY, GENERAL
HS SURGERY, HAND
HNS SURGERY, HEAD AND NECK
NS SURGERY, NEUROLOGICAL
ORS SURGERY, ORTHOPEDIC
PDS SURGERY, PEDIATRIC
PS SURGERY, PLASTIC
TS SURGERY, THORACIC
TRS SURGERY, TRAUMATIC
U SURGERY, UROLOGICAL

In addition to the above specialties the following designations are also used:
OS Other, i.e., physician designated a specialty other than those appearing above.
US Unspecified, i.e., physician did not specify a specialty.

The following is an unabbreviated description of the types of forms listed on the Physician Enrollment Application.

FORM#	*NAME*
*DPA 1443	Provider Invoice (Claim Form)
DPA 2189	Sterilization Consent
DPA 1409	Prior Approval, Other
DPA 2239	Prior Approval, Transportation
DPA 1977	Hysterectomy Informed Consent
DPA 1410	Payment Adjustment Request
DPA 1862	Abortion Certification
PH 0600	Medichek Invoice (Claim Form)
†DPA 2240	PriorApproval Equipment

*The MMIS Claim Form is DPA Form 2360. You will notice that the Provider Invoice on the Physician Enrollment Application is DPA Form 1443. When ordering claim forms mark the space for DPA Form 1443 and IDPA will provide you with the correct claim form.

†Leave this block blank when completing the Enrollment Application.

Be Sure To Sign and Date the Form.

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

MEDICARE ☐ MEDICA D ☐ CHAMPUS ☐ BLUE SHIELD ☐ OTHER ☐

JJJ

PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME): Required

2. PATIENT'S DATE OF BIRTH: Conditionally Required — AGE

3. INSURED'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)

4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE) — TELEPHONE NO.

5. PATIENT'S SEX: MALE ☐ FEMALE ☐

6. INSURED'S ID AND/OR MEDICARE NO. (INCLUDE ANY LETTERS)

7. PATIENT RELATION TO INSURED: SELF ☐ SPOUSE ☐ CHILD ☐ OTHER ☐

8. INSURED'S GROUP NO. (GROUP NAME) AND/OR MEDICAID NO.: Required

9. OTHER HEALTH INSURANCE COVERAGE - ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER

10. WAS CONDITION RELATED TO: Conditionally Required
A. PATIENT'S EMPLOYMENT: YES ☐ NO ☐ — B. ACCIDENT: AUTO ☐ OTHER ☐

11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING)
SIGNED — DATE

13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICES DESCRIBED BELOW
SIGNED (INSURED OR AUTHORIZED PERSON)

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)

15. DATE FIRST CONSULTED YOU FOR THIS CONDITION

16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOM? YES ☐ NO ☐ — CHECK HERE IF EMERGENCY ☐

17. DATE PATIENT ABLE TO RETURN TO WORK

18. DATES OF TOTAL DISABILITY: FROM — THROUGH

DATES OF PARTIAL DISABILITY: FROM — THROUGH

19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (e.g. PUBLIC HEALTH AGENCY): Conditionally Required — PROVIDER NUMBER: Conditionally Reqd

20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES: ADMITTED — DISCHARGED

21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE): Conditionally Required

22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES ☐ NO ☐ CHARGES:

23A. EPSDT: Cond Required YES ☐ NO ☐

23B. FAMILY PLANNING: Cond. Required YES ☐ NO ☐

23C. STERILIZATION/ABORTION: Conditionally Required YES ☐ NO ☐

23D. PRIOR AUTHORIZATION NUMBER: Conditionally Required

23E. T.O.S.*: Required

23F. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: Conditionally Required

This section is incorrectly labeled in the IDPA Handbook as "required". Consult accompanying instructions to correctly complete this field.

24. REPEAT	A. DATE OF SERVICE	B. P.O.S.*	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES) PROCEDURE (CODE) (CENT FY)	MOD	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	DELETE
Optional	Required	Reqd	Required	Cond Reqd		Required	Cond. Required	Optional
2								
3								
4								
5								
6								
7								

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (I AGREE TO COMPLY WITH THE REQUIREMENTS IN THE CERTIFICATION WHICH APPEARS ON THE REVERSE OF AND IS A PART OF THIS BILL)
Required
SIGNED — DATE Required

26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY - SEE BACK) YES ☐ NO ☐

27. TOTAL CHARGE: Required

28. AMOUNT PAID: Conditionally Required

29. BALANCE DUE: Conditionally Required

30. YOUR PROVIDER NUMBER: Required

31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE: Required

32. YOUR PATIENT'S ACCOUNT NUMBER: Optional

33. YOUR EMPLOYER ID NUMBER: Conditionally Required

34. NUMBER OF SECTIONS: Required

35. ORIGINAL DCN: Conditionally required

36. ORIGINAL VOUCHER NUMBER: Cond Required

37A. TPL CODE	37B. TPL STATUS	37C. TPL AMOUNT	37D. TPL DATE	38A. TPL CODE	38B. TPL STATUS	38C. TPL AMOUNT	38D. TPL DATE
Cond Required	Cond Required	Cond Required	Cond Required	Cond Required	Cond Required	Cond Required	Cond Required

* PLACE OF SERVICE (P.O.S.) AND TYPE OF SERVICE (T.O.S.) CODES ON THE BACK

REMARKS:

Form HCFA 1500
ILLINOIS DPA 2360 (N-1-81)

SAMPLE

MMIS Form DPA 2360 Instructions

Field	Completion Status	Item
1	Required	*Patient's Name*—Enter patient's name exactly as it appears on the Medical Eligibi ty Card. Do not punctuate after middle initial.
2	Conditionally Required	*Patient's Date of Birth*—Use month, day & year format including zer (e.g.,Jan.1,1981: 010181)—from eligibility card *only* when billing for 1) Newbo care or 2)When interim eligibility card has no recipient number.
8	Required	*Medicaid Number*—Enter the nine digit number next to patient's name from t Medical Eligibility Card. Do *not* use case I.D. number.
10	Conditionally Required	*Condition Related to Employment/Accident*—If treatment is sought for injury illness that resulted from employment, or an accident, complete the appropria YES box with a capital "X". It is not necessary to complete the boxes labeled NO treatment is unrelated to employment or an accident.
19	Conditionally Required	*Referring Physician's Name & Number*—Enter *both* name and Illinois State Licen Number or AMA Number or Social Security Number of referring physician *o* when billing for 1) Consultation or 2) A portion of OB care.
21	Conditionally Required	*Facility Where Services Rendered*—Enter name and city of facility—if other th office or patient's home. (Street address is unnecessary and abbreviations *withc* punctuations are accepted.)
23A,B	Conditionally Required	*EPSDT & Family Planning*—Only enter a capital "X" in the YES box if billing f Medichek (EPSDT) screening or family services. Again, if treatment is unrelat to Medichek or Family Planning the boxes labeled NO need not be completed.
23C	Conditionally Required	*Sterilization/Abortion*—Enter a capital "X" if billing for a sterilization or an abo tion *and* attach the appropriate forms with paperclip *only*. Be sure to mail doc ments in special approval envelope.
23D	Conditionally Required	*Prior Authorization No.*—Include *only* when services billed require prior IDF approval, (e.g. Bypass Surgery for morbid obesity). The number is from the Pri Approval Request and is rarely utilized.
23E	Required	*T.O.S. (Type of Service)*—Enter corresponding code from reverse side of billi form for type of service rendered.
23F	Conditionally Required	*Diagnosis or Nature of Injury or Illness*—Enter a written diagnosis to explain tre ment *only* when a coded diagnosis is not available from the listing in the Handbo or from ICD-9-CM *and* enter 9999 in Block 24D.
24	Optional	*Repeat Code*—Enter an "X" in the box provided if the data fields in the servi section mirror the above service with the exception of the date of service. A date service *must* be entered for each section.
24A	Required	*Date of Service*—Use month, day & year format. Do not use slashes, hyphens spaces and be sure to include zeros—if needed—to complete the six-digit field.
24B	Required	*P.O.S. (Place of Service)*—Enter the numeric code identifying place of servi (List of codes on reverse of Claim Form.)
24C	Required	*Procedure Code/Drug Item No.*—Enter the appropriate code specified in IDF Handbook, if not specified, from CPT-4. Enter eight-digit drug item number wh billing for dispensed drugs.
	Conditionally Required	*Modifying Units*—Enter appropriate code only to identify *anesthesia* modifier unit
24D	Required	*Diagnosis Code*—Enter the ICD-9-CM code or the code from IDPA Handbo Appendix for the primary and, if available, the secondary diagnosis. Do *not* inclu a decimal point or a space.
24E	Required	*Provider Charges*—Enter total charge for the service section, not deducting thi party liability (TPL).
24F	Conditionally Required	*Days/Units*—A four digit entry is required *only* 1) For Anesthesia Services, When billing for a drug item, 3) Billing as an Asst. Surgeon, and 4) When allow ble mileage is charged. (See Appendix A-1(7) of the new Handbook for specifics.

Field	Completion Status	Item
24F	Optional	*Delete*—If you have erred in typing a service section and you are unable to correct it, enter an "X" to delete the entire service section.
25	Required	*Physician's Signature & Date Signed*—The signature must be black or dark blue ink. Stamps or facsimile signatures will not be accepted by IDPA. Data in MMDDYY format.
27	Required	*Total Charge*—Sum of charges submitted on the claim. Do not include service sections that are marked as deleted.
28	Conditionally Required	*Amount Paid*—You must enter the sum of payments received *only* if there is third party liability. Otherwise leave the block blank. (This was incorrectly labeled as a "Required" field in the IDPA Handbook.) Do not use a decimal point or a space between dollars and cents.
29	Conditionally Required	*Balance Due*—Again, *only* if there is third party liability need this block be completed. Enter the difference between "Total Charges" and "Amount Paid" (by third party). (This too, was incorrectly labeled as a "Required" field by IDPA.)
30	Required	*Provider No.*—You should enter your Provider Number as it appears on the Provider Information Sheet. You should have received this document upon returning the Physician Enrollment Application to IDPA for re-enrollment.
31	Required	*Physician's Name & Address*—Again, you should enter physician's name and address as it appears on the Provider Information Sheet.
32	Optional	*Your Patient's Account No.*—This block allows you the opportunity to include your own patient account number. The number you use in this field will appear on the remittance advice you receive when you are reimbursed.
33	Conditionally Required	*Employer I.D.*—Enter the number next to the payee from the Provider Information Sheet (See Section II of Physician Enrollment Application) to whom payment for claim is to be sent. If no number (1 through 4) is entered, payment will automatically go to address listed as #1 Payee (1).
34	Required	*No. of Sections*—Enter the number of service sections (1 through 7) *correctly* completed. Do *not* count deleted entries.
35	Conditionally Required	*Original DCN (Document Control No.)*—This field is *only* completed when you are rebilling the Department for a previously submitted claim that is over six months old but within a year of the date of service.
36	Conditionally Required	*Original Voucher No.*—As in the item above (#35), the original voucher number is entered *only* when you are rebilling IDPA for a rejected bill that is over six months old but less than one year old.
37A	Conditionally Required	*TPL (Third Party Liability) Code*—This code is listed on the Medical Eligibility Card. It 1) Dictates a third party should be billed prior to billing IDPA and 2) Signifies the name of the third party carrier. (The name appears on the Remittance Advice if the claim is not paid by the Department.) If there is TPL, enter the code listed; if none is listed, check in General Appendix 9 in the new IDPA Handbook for the appropriate code.
37B	Conditionally Required	*TPL Status*—This is a two-digit code indicating the status of the third party billing. A code must be entered *only* when TPL is involved. (A list of these status codes is found in Appendix A-1 (10) of the new IDPA Handbook.)
37C	Conditionally Required	*TPL Amount*—The amount received from any third party should be entered corresponding to Items #37A and #37B. If there is no TPL received, no entry is required.
37D	Conditionally Required	*TPL Date*—If the claim was not submitted to the Department before the six-month time limit, *and* specific TPL status codes (#37B) are utilized explaining the disposition of third party adjudication, then a date should be entered. This date will be utilized by IDPA in determining the allowable period for filing the claim. (See Appendix A-1 (11) of the new IDPA Handbook for specific TPL status codes.)

Special Note

Those fields *not* itemized in the above instructions are considered by IDPA to be completed **at your option.** They are not required. ◀

Answers to Common Questions

Certain aspects of the MMIS system have resulted in a large volume of inquiries from physicians. The most common inquiries are listed below for your information.

When must the referring practitioner name and number be listed?

Only when billing for a consultation or when billing for a **portion** of obstetrical care. (If billing for total OB care, including delivery, this need not be used.)

*If a physician provides more than one type of service to a patient (e.g. Medical Care vs Surgery) must a different form be submitted for each **type** of service rendered?*

Yes

How should the Diagnosis Code be handled?

IDPA is required by HCFA to collect Diagnosis Codes as part of the MMIS system. The Diagnosis Codes may either be taken directly from ICD-9-CM (INTERNATIONAL CLASSIFICATION OF DISEASES, CLINICAL MODIFICATION, 9th Edition) *or* from the abbreviated list of codes which is contained in the new Handbook. If a code is not in the abbreviated listing, physicians should enter 9999 in Box 24D and provide a handwritten diagnosis in Box 23F. **You must enter a diagnosis code in Box 24D. You *need not* enter a handwritten diagnosis in Box 23F unless Code 9999 is used in Box 24D.**

Does the Diagnosis Code correlate to the procedure code on the same line?

The Diagnosis Code should report the condition primarily responsible for the patient's treatment described on the entire billing form and not necessarily for specific service sections. For example, if seven procedures were billed on one billing form, each having a differing diagnosis, the physician need only designate a primary and secondary diagnosis.

If I elect to use the multiple payee option, how will my IRS 1099 forms be handled?

If an FEIN is listed with the payee information, the 1099 will be credited to the corporation. If no FEIN is listed, the 1099 will be credited to the Social Security Number of the individual.

How does a physician report a change of address or a request for additional forms to IDPA?

When a physician is accepted into the Medicaid program, he receives a copy of a document called the Provider Information Sheet. This document contains a listing of all the information which the physician has provided to the Department. To change any item listed, mark the change on the Provider Information Sheet and return it to IDPA. An updated information sheet will then be returned to the physician.

Since IDPA will mail my checks to separate offices, will they also send my billing forms to each of my offices?

No—not as a matter of routine policy. However, if unusual hardships result, some exceptions will be made. Requests for exceptions should be directed to Keith Vangeison, Chief, Bureau of Provider Services, Illinois Department of Public Aid, 931 East Washington, Springfield, Illinois 62763.

If the billing forms are damaged in transit, how do I get additional forms?

Call the Provider Participation Unit, 800-252-8937.

What does a Radiologist enter for a diagnosis?

Either the Actual Diagnosis or (if negative) the suspected diagnosis or rule-out.

Can my staff personnel authorized by me to sign IDPA claim forms continue to do so?

Yes. As is currently the case, your authorized staff is still entitled under MMIS to sign the claims on your behalf.

How does an ophthalmologist who dispenses eyeglasses bill the Department under the MMIS system?

Ophthalmologists billing for the dispensing of approved eyeglasses must use DPA 1443 Provider Invoice, making the appropriate entry in Field #29 of the form. Special instructions for this type of billing may be obtained from the IDPA Provider Participation Unit by calling the toll free number 800-252-8937. ◀

Pulse of the ISMS Auxiliary

I Am S.A.S.I.I.

By Mrs. Donald Hinderliter/Rochelle

The idea for S.A.S.I.I.'s inception began when the AMA Auxiliary focused on RP/MSS (Resident Physician/Medical Student Spouse). S.A.S.I.I. stands for Sponsor A Spouse In Illinois. The program was introduced at Fall Conference in 1980 and promoted statewide. Letters were sent to all counties after Fall Conference containing information about the S.A.S.I.I. program. The program was implemented as follows:

The sponsor (a spouse of a physician) sends $5.00 to the S.A.S.I.I. chairman as a sponsorship fee. The S.A.S.I.I. chairman sends the $5.00 to the state treasurer along with the sponsor's name and the name and address of the RP/MSS. The treasurer then sends $3.00 on to the AMA Auxiliary for national dues, along with the RP/MSS's name and address, and keeps $2.00 in the state treasury for Illinois dues. No county dues are charged to RP/MSS. However, these spouses are eligible to attend county meetings in the county of residence. The S.A.S.I.I. chairman then sends a S.A.S.I.I. button for the sponsor to wear, to attract interest to the program. A form letter is also sent to the sponsor to be used as a guide when writing to the RP/MSS. This letter is to be written in the sponsor's own handwriting to give the letter a personal touch. The name and address of the RP/MSS is included with the form letter. Sponsors are encouraged to treat their RP/MSS as a "Pen Pal" and keep them informed of what is being done in the counties, what is going on at the state and national level, and share with them what project bank could offer. They are also encouraged to have the RP/MSS inform them when they receive their membership card from the AMA Auxiliary.

The S.A.S.I.I. program is basically a program to inform RP/MSS that the medical auxiliary exists, and that there is a publication, *Horizons,* especially for them. RP/MSS also receive *Facets* and the availability of the project bank and package programs.

A new membership award was given at our Annual Meeting this year in conjunction with the S.A.S.I.I. Program, to the county that sponsored the most RP/MSS. The award was presented to St. Clair County for sponsoring 22 RP/MSS.



ISMSA President-Elect, Mrs. Donald Hinderliter (l) with ISMSA President Mrs. Bonnie Keegan, promoting the S.A.S.I.I. poster and symbol.

Illinois had 105 S.A.S.I.I. members this year. RP/MSS count as full members and as a result our state was able to gain another delegate to the national convention.

National News Update

ISMSA received two national awards during the annual AMAA meeting. The AMA Auxiliary granted a membership award to ISMSA in recognition of outstanding achievement in recruiting and retaining members. In addition, the American Medical Association Education and Research Foundation presented an achievement award to ISMSA, in gratitude for outstanding service to, and support of, the Foundation and its aims. ◀

Case Reports

Recurrent Giant Air Cyst Of The Colon

By Thomas G. Cronin, Jr., M.D., Mona Sue Tway, M.D.
and Carl T. Boraca, M.D./Evanston

Giant air cyst of the colon is an unusual complication of diverticulosis and diverticulitis. During colon examinations, these giant air cysts fill with barium approximately half of the time and, in some rare cases, a communication with the colon cannot be found even at pathologic examination. Because of this, 25% of the cases have been treated surgically with a simple cystectomy type of surgical procedure without complication. We wish to report the first known complication of the cystectomy procedure, recurrence of the giant air cyst, and to stress this disease process is a complication of diverticulitis and the surgical procedure of choice should be removal of the cyst along with the contiguous colon.

Giant air cyst formation is a rare complication of diverticular disease of the colon. The most prevalent and likely theory of its pathogenesis is inflammation at the neck of a diverticulum causing a ball—valve type of obstruction. This allows colon gas to enter the cyst, presumably during defecation. This gas is then trapped in the cyst by the inflammation at the neck of the diverticulum. In some cases it may be vented irregularly back into the colon, resulting in increases and decreases in size over a period of time. Ordinarily, the cyst is easily mobilized from surrounding structures at surgery, making a simple cystectomy type of surgical procedure a very attractive option. This is particularly true in the elderly population in which this disease occurs. Fully 25% of the cases have been treated in this manner. We wish to report the first known complication of this procedure

Report of Case

An 80 year-old white female presented with vague low to mid-abdominal pain of several months' duration and chronic constipation. There was no history of nausea, vomiting, fever, or melena. Prior surgeries included hysterectomy and oophorectomy, cholecystectomy, and ventral herniorrhaphy all at other institutions and at uncertain, but distant, dates. Physical examination revealed a soft, fixed left lower quadrant mass, approximately 10cm. in diameter. She exhibited tenderness to palpation in the region of the mass. No rebound tenderness was present. Stool guaiac was negative for occult blood. The remainder of the laboratory findings were non contributory. A film of the pelvis (Figure 1) obtained during intravenous urography revealed a 10cm. U-shaped gas filled structure. There was a question of a septum or valvula conniventes within the mass. The IVP showed it was separate from the urinary tract. A barium enema (Figure 2) showed numerous diverticula, particularly in the sigmoid colon. The gas filled mass was at the apex of the recto-sigmoid colon and at no time did barium fill this air cyst. Because of increasing tenderness in the region of the mass, the patient was taken to surgery. Proctoscopy

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CARL T. BORACA, M.D., is a board certified anatomic and clinical pathologist affiliated with St. Francis Hospital in Evanston. Dr. Boraca is a clinical instructor in pathology at the UI Abraham Lincoln School of Medicine and director of pathology resident training at St. Francis Hospital. He is a fellow of both the American Society of Clinical Pathologists and the College of American Pathologists.



Figure 1
There is a large air filled mass in the pelvis, separate from the urinary tract.



Figure 2
Barium enema examination shows this mass to be at the apex of the recto-sigmoid colon. Numerous diverticula are present. Barium does not enter the air filled mass.

under general anesthesia at the time of surgery was negative to 14 cm.

A standard lower midline incision was made. In the lower abdomen, a balloon-like cystic mass with a thin adhesive band giving it a bilobed appearance was encountered. This cystic lesion was located on the anti-mesenteric border of the recto-sigmoid colon surrounded by adhesions. No free communication with the colon could be identified and no vascular supply to the cyst was present. During the procedure of freeing the cyst from the adhesions, its wall was inadvertently punctured and a large gush of odorless gas was emitted with total decompression of the cyst. There was no fluid or purulent material in the cyst. The cyst was resected, the anti mesenteric border of the colon was oversewn and the abdomen closed. The patient's immediate post surgical course was uneventful. Histologically, the cyst wall consisted of a serosal covering, sparse and irregularly arranged smooth muscle bundles, and a granulation tissue lining. The smooth muscle varied in amount, being greatest at the base of the cyst and least at the dome. Approximately two months post-op the patient presented with recurrent symptoms and a palpable pelvic mass. Repeat IVP and barium enema (Figures 3 and 4) revealed recurrence of the giant air cyst. Again, it did not fill with barium. She refused definitive surgery.

Comments

Although some may disagree, we do not feel the presence of smooth muscle in our lesion classifies it as a congenital problem. Colonic duplications are a problem of the young, anatomically arising from the mesenteric border of the bowel, with a distinct blood supply.[1] Giant air cysts are a disease of the elderly, anatomically located on the anti-mesenteric border of the colon, with no distinct blood supply.[2,3] Also, our patient had had two prior abdominal surgeries without mention of this large cyst. Cohen[4] has stated that some muscularis is occasionally found in pulsion diverticula.

Giant air cysts of the colon (also referred to as giant diverticula) do not always fill with barium during colon examinations. Several review articles place the incidence of their filling with barium at anywhere from 33%[2,5] to 66%[3] of the time. Two cases have been reported without apparent anatomic communication with the colon at pathologic examination,[6,7] and many times the communication is not apparent until close pathologic and sometimes microscopic examination is done. Although most authors feel that these giant air cysts are a complication of diverticulitis, approximately 25% of the cases[3] have been treated by simple removal of



Figure 3
The air cyst has recurred. Note the clip from the previous operative procedure.

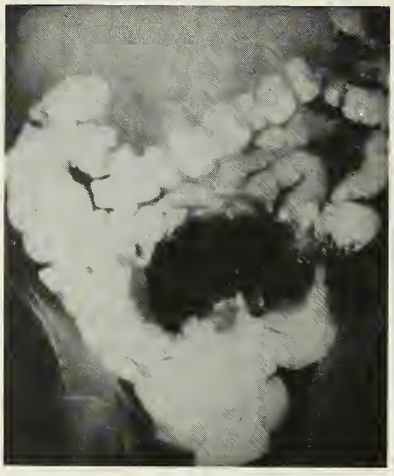


Figure 4
Repeat barium enema reveals an almost identical appearance to the initial exam.

the cyst, without subsequent problems. We believe that our case is the first complication of this procedure reported in the literature. Although giant air cysts tend to occur in an elderly population, making simple cystectomy an attractive procedure, we agree with other authors[3,5] that the underlying disease process is diverticulitis and the surgical procedure of choice is removal of the cyst and adjacent colon. This case report of recurrence of the giant air cyst after simple cystectomy supports that opinion. ◀

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Case Reports

Gastrocolic Fistula Complicating Benign Un-Operated Gastric Ulcer

BY JONG D. LEE, M.D./HAVANA

An unusual case of gastrocolic fistula secondary to benign gastric ulcer is presented. In a review of the literature, the most frequent symptomatic manifestations are abdominal pain, weight loss, diarrhea, and feculent vomiting. The patient taking aspirin and steroid is vulnerable to this complication. The diagnosis is often made by barium enema, but gastroscopic examination is helpful to exclude the presence of malignancy. One stage enblock resection of the fistula is the treatment of choice after adequate pre-operative preparation.

The first documented gastrocolic fistula, reported in 1755 by Haller,[1] was secondary to a perforated carcinoma of the stomach into the transverse colon. Since then, malignancy has been implicated as the most common cause of gastrocolic fistula.[2,3] Although other causes of gastrocolic fistula are diverticulitis of the colon, ulcerative colitis,[4] pancreatic abscess, intestinal tuberculosis, syphilis, radiation,[3] and iatrogenic factors, it rarely occurs spontaneously in patients with benign peptic ulcer disease in the absence of previous gastric surgery. In a review of literature, it would appear that the patient taking steroid and aspirin is at a high risk of developing a gastrocolic fistula complicating a benign un-operated gastric ulcer.[5,6] Recently we have treated a patient with a gastrocolic fistula, caused by a benign gastric ulcer and most likely related to steroid and aspirin medications taken for rheumatoid arthritis.

Jong D. Lee, M.D., is a board certified general surgeon and a fellow of the American College of Surgeons. Dr. Lee is on the active medical staff of Mason District and Graham Hospitals.

Case Report

A sixty-year-old white female was admitted for investigation of chronic weight loss and diarrhea. The patient had experienced a rather severe diffuse abdominal pain six months prior to this admission. Since then she had had gradual weight loss, 60 pounds in six months, and chronic intermittent diarrhea. She had frequent episodes of nausea and vomiting. Her husband claimed that the vomitus was occasionally foul-smelling and fecal in nature.

The past medical history was significant in that she had had rheumatoid arthritis for four years and taken steroids and aspirin off and on for approximately two years. (The patient had been mostly on aspirin but it was replaced by oral steroid therapy for a short period, approximately two - three weeks while her arthritis flared up badly. It had occurred two or three times in the last two years. In addition she had received multiple intraarticular injections of steroids occasionally.) Eighteen months before admission, at a near-by local hospital, she had had a barium meal and barium enema studies which were normal except for a small hiatal hernia. One month before admission, she entered the same hospital with mild upper G.I. bleeding, whose exact cause was not determined and was treated with blood transfusion, cimetidine and iron.

Physical examination revealed an emaciated white woman appearing moderately dehydrated and chronically ill and looking much older than her stated age. Blood pressure was 130/70mmHg, pulse was 82 beats per minute, body weight was 99 pounds. There were the classical ulnar deviations of both hands from rheumatoid arthritis. Heart and lungs were within normal limits. Abdomen revealed neither tenderness nor a palpable mass.

Laboratory results were as follows: HgB, 11.8 gm/100 ml; Hct, 35%; WBC counts, 8,600/cumm, with 69% neutrophils and 21% lymphocytes; sodium, 136 CEq/L; potassium, 4.6 MEq/L; chloride, 110 mEq/L; FBS, 87 mg/100ml; BUN, 10mg/100ml; cholesterol, 130mg/100ml; ESR, 34 mm. the first hour. The total bilirubin was 0.4mg/100ml; and total serum pro-



Figure 1
Barium enema demonstrating reflux of contrast material into the stomach through the gastrocolic fistula.

tein was 5.0 mg/100ml, with albumin 2.8 mg/100ml. Prothrombin time was 12.6 seconds; rheumatoid factor and ANA were positive; Serum iron was 38 micrograms/DL total iron binding capacity, 301 micrograms/DL, with 13% saturation; serum Vit.B12 assay was 725 PG/ML serum folate assay, 7.0 PG/Ml, fasting serum gastrin was 159 picrograms/ML; stools were guaiacpositive for occult blood.

X-ray film of the chest and electrocardiogram were normal. Upper G. I. series revealed a small hiatal hernia with limited reflux. The stomach was deformed along the greater curvature side of the distal body and antrum. No ulcer crater was demonstrated. Barium enema showed a gastrocolic fistula, the fistula tract connecting the greater curvature of the stomach to a very redundant transverse colon.

Gastroscopic examination showed a deeply seated ulcer on the distal greater curvature. During the procedure, feculent liquid substance kept coming up onto the ulcer bed and had to be flushed out with an irrigation solution to visualize an ulcer clearly. The report of multiple biopsies disclosed a benign gastric ulcer.

Hospital Course

Patient was placed on nutritional support with elemental diet and received 5% albumin to bring serum albumin level up to normal. Fluid and electrolyte imbalance was corrected. Bowel preparation consisted of mechanical cleansing and oral antibiotics of short duration with neomycin and erythromycin base. At abdominal exploration the mid-transverse colon was found to be caught up in an inflammatory mass extending to the greater curvature of the stomach and attaching posteriorly to the pancreas. Approximately 60% of the distal stomach and a generous segment of the mid-transverse colon, including the fistulous tract, were resected en-block. Gastrointestinal continuity was established by a Billroth 1 gastroduodenostomy (Schoemaker modification) and end-to-end anastomosis of the transverse colon. The pathologic report was a benign gastric ulcer with gastrocolic fistula; no malignancy was found. The patient made an uneventful recovery from the surgery and was dismissed on the tenth post-op. day. She was referred to a rheumatologist to control her arthritic pain with non-ulcerogenic medications. At last follow-up she became free from gastrointestinal symptoms and was starting to gain weight.



Figure 2
Fistulous tract between the greater curvature of stomach and mid-transverse colon.

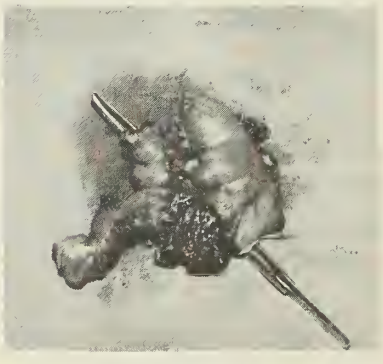


Figure 3
Unopened specimen showing connection between stomach and transverse colon.



Figure 4
A large gastric ulcer, fistulous tract and colonic mucosa are also shown.

Discussion

Gastrocolic fistula has been described commonly as gastrojejunocolic fistula occurring after inadequate ulcer surgery. Cancer of the stomach and colon is the most common nonsurgical cause of the gastrocolic fistula.[2,3,7] However, the spontaneous perforation of a benign gastric ulcer into the colon is rare; a little more than 50 cases of gastrocolic fistula from benign non-operated gastric ulcers have been reported in the English literature.

In 1976, the Mayo Clinic collected 42 cases from the literature,[8] including four cases of their own, and reported that the common symptoms are abdominal pain in 83%, diarrhea in 74%, weight loss in 74%, vomiting in 74%, and foul eructations or fecal vomiting in 55%. Of the 42 cases, eight patients had a history of aspirin ingestion and nine patients had previously taken steroids.[8] It appears that the patient taking aspirin and steroid for rheumatoid arthritis is at high risk of developing this complication,[5] such as in the presented case. The presence of gastrocolic fistula is often suggested by careful history taking, the clues being feculent vomiting and watery di-

arrhea containing undigested food. It seems apparent that the cause of the diarrhea is fecal reflux into the stomach and small bowel.[9]

Barium enema is the most reliable means of diagnosing a gastrocolic fistula, demonstrating a fistula in 95% of the cases; a barium meal study is diagnostically relevant in about 27%.[7] Gastroscopy was used in this case. It would be an important adjunctive diagnostic tool because the finding of fecal eructation in a deeply penetrating peptic ulcer certainly indicates the presence of a connection between stomach and colon. In addition, biopsies and gross appearance of the ulcer often establish the benign nature of the lesion.[10]

Pre-operative preparation of the patient is important and must include correction of electrolyte imbalance, anemia and malnutrition. Adequate bowel preparation is mandatory. These preparations are vital in order to avoid high mortality which was reported to be 17%[8] overall. Despite the earlier recommendation of staged operation with preliminary proximal colostomy, the surgical procedure of choice is one stage enblock hemigastrectomy and resection of the involved segment of the colon and fistula tract. Gastrointestinal continuity can be re-established by Billroth 1 of gastroduodenostomy and end-to-end anastomosis of the transverse colon. ◀

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Instructions for Authors

Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order*: Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

Authors whose manuscripts are accepted will be asked to sign a copyright release form to the *Journal.* The *Journal,* however, will secure author permission before authorizing a reprint.

Medical Student Section in Action

A Medical Education: Only For The Rich?

Medical education in the United States is regarded as the finest in the world. The commitment to the patient care, ongoing research, and continuing technological progress assures the student of getting necessary exposure to the art and science of medicine. Only a few individuals, however, have the desire to attain a doctor of medicine degree. The rigors of medical school, residency, and even medical practice seem to detract from the attractiveness of such a career. Recently, an additional contraindication has come to view; it is extremely expensive to pursue medicine as a vocation.

Forbidding costs will certainly diminish the hopes of aspiring doctors nationwide. Worse, diversity among medical students, only just recently achieved, will no doubt be sacrificed. Minorities, the poor, and even the middle class may be unable to finance soaring tuition costs. Diversity, possibly the greatest strength of medical education in America, is soon to be a dying creature.

How much does it cost a student to attend medical school in the United States for one year? For the 1980-81 school year, the cost of one year attendance for an unmarried student at a public medical school was $7,400. This was up $900, or 12%, from 1979-80. For an unmarried student at a private school, it cost $13,400 for the 1980-81 year. This was $2,000 more than in 1979-80—up 14%. Medical students with no income have no defense against inflation and rising costs. Who then, should pay to educate America's future physicians?

The American Medical Association/Medical Student Section set up an Ad Hoc Committee on Financial Aid to study the dilemma. They concluded ". . . The burden of financing medical education should be borne by those who benefit from physician services as well as those soon to become physicians. Therefore, federal and state governments, the private sector, medical students, and their families should share the responsibility of funding" Naturally, medical students do not deserve a "free ride," but can they really be expected to finance such a costly education alone?

The federal government once allocated $2,000 per medical student per year to each medical school. This direct capitation has decreased to $639 in 1981. Severe cuts in financing research in medical schools (indirect aid to medical education) have occurred at the federal level. Even the loan programs available to students are being curtailed.

Many loan programs are still available to assist in financing medical school tuition and expenses. The Federally Insured Student Loan/Guaranteed Student Loan program assures in-school interest subsidies and no repayment until after graduation. However, only $5,000 can be borrowed yearly and a maximum of $25,000 (this includes college loans) is enforced. This program needs to be expanded at the current 9% simple interest rates, but the Reagan Administration seeks cuts.

Other programs with in-school interest subsidies and 9% simple interest include the Health Professions Student Loan Program and the National Direct Student Loan program (4% interest). These programs, however, are available in cases of special financial need. As with other Washington budget cuts, these programs will probably suffer.

The National Health Service Corps (NHSC) and Health Professions Scholarship Program (HPSP) were developed to ensure an adequate supply of health manpower in shortage areas and in the armed services, respectively. Each scholarship recipient is awarded tuition and fees, a monthly living stipend ($485), and an annual supplement. In exchange for one year of support, the student agrees to serve for one year in the sponsor organization. Though the HPSP will continue, the NHSC will offer no new scholarships for the 1981-82 school year.

The Health Education Assistance Loan (HEAL) program seems to be the loan alternative of the future. Unfortunately, forbidding interest rates could lead to the financial demise of the borrower. Though students may borrow up to $15,000 per year, interest rates are equal to Treasury Bill rate plus 3.5%. Currently, this is 19.5%. If a student borrowed $10,000 per year for four years at only 15% interest, the payback over 10 years would amount to $192,000 (this payback begins three years after graduation). Assuming that 15 years are needed to repay, the amount increases to $252,000. Such a loan program would serve only to increase the default or bankruptcy rate of young physicians.

Part two of this series will consider possible solutions to these issues. ◀

Michael L. Nieder
Chairman, ISMS/MSS

Illinois Society, American Association of Medical Assistants

Doctor: You Are Invited

By Mari Lakadat, McLean County Chapter

An invitation is extended for your presence at a meeting of a county chapter of the A.A.M.A. Please accept. Tangible evidence of the benefits of A.A.M.A. to you and your medical assistant is apparent at each chapter meeting.

Would it help to know that your medical assistant, well versed in your office procedures, is in company of other professionals, communicating, learning? Professionalism for the medical assistant means familiarization with new technologies, perfection of standard office procedures, and an integration of effective environmental factors.

A medical assistant is called the most versatile member of the health care team and the most integral part of a physician's office setting. A.A.M.A. provides the opportunity to the medical assistant for certification of ability and enhancement of office training.

The members of a chapter may represent several specialties in medical care, with each member contributing information, terminology and knowledge indigenous to that specialty.

Attending a meeting offers the opportunity to see the organizational aspect of A.A.M.A. at work, often giving members their first participation in an organizational process. Perhaps the group will then adjourn to a guided study program, supplied through A.A.M.A., or a physician will present an educational lecture guaranteed to perk up your medical assistant's interest. A panel discussion may be on the agenda regarding office procedures, or a community organization representative may provide an informative presentation.

The members of your local A.A.M.A. chapter are nurses, bookkeepers, receptionists and other key office personnel. The dominant motivating force for these members is the provision of consistent and compassionate health care to your patients.

Is there an employee in your office whose leadership qualities are becoming apparent? Is there an employee in your office who does the best within the framework of her job description, but with proper guidance and encouragement could exceed your expectations? Can you see your medical assistant involved in an organization stressing professionalism and educational endeavors? If so, Doctor, you are invited to participate in the 25th year of A.A.M.A., recognizing and encouraging self improvement endeavors on your behalf by your medical assistant. Please accept our invitation. ◀

Information about Illinois Society, AAMA, may be obtained from Mary Lu Ostrowski, CMA, President, Illinois Society, 1704 East Jackson Street, Bloomington, Illinois 61701, or Mari Lakadat, Chairman, Public Relations Committee, c/o William Sawyer, M.D., 107 East Chestnut Street, Bloomington, Illinois 61701.

ISMS At The Bat

PHOTOS AND VERSE BY EDWARD S. STECKI

On Monday afternoon, June 8, the ISMS Delegation to the AMA faced the California AMA Delegation in a softball game at Chicago's Grant Park. The following is an eyewitness account of that contest.



The outlook wasn't brilliant for the ISMS team that day.

The score stood eleven-three with but two innings left to play.



Another Californian crossed the plate;
still one more did the same.



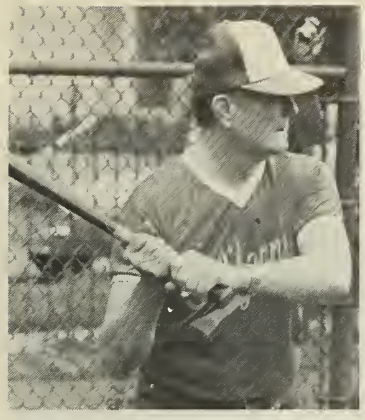
And a sickly silence fell
upon Illinois Docs
in the game.



Yet another batter
smashed one;
the ball flew
off the bat.



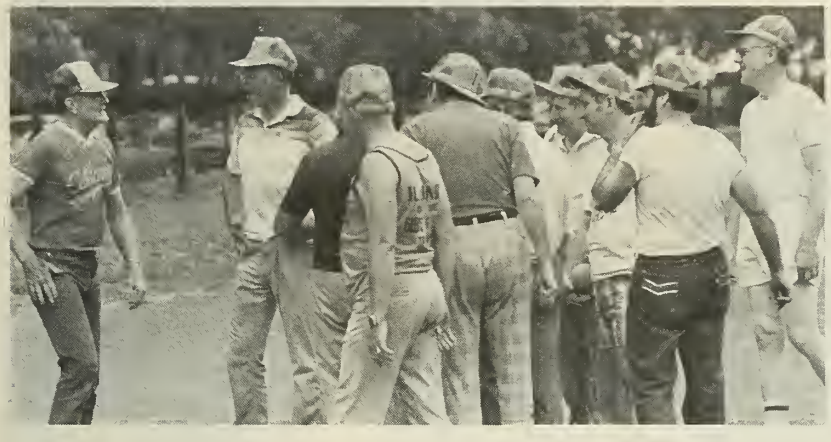
But Joe "Sure Hands" Skom speared it,
though it knocked askance his hat.



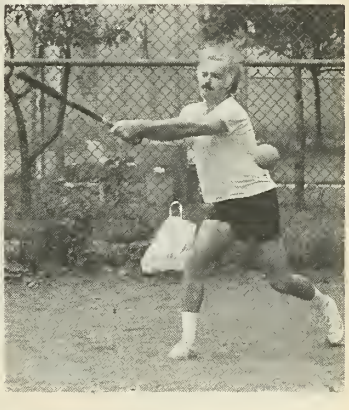
Then the next one up drove it hard,
and the strangest thing occurred.



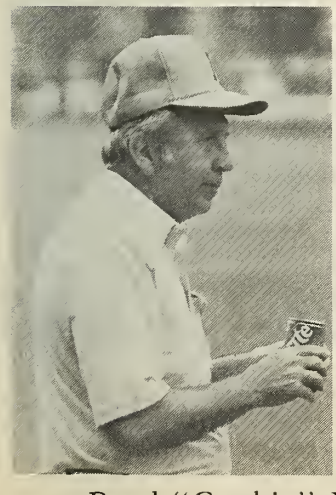
When the dust had settled,
John "Hot Corner" Seward
caught him off of third.



Though the call was protested, ISMS' arguments held fast.



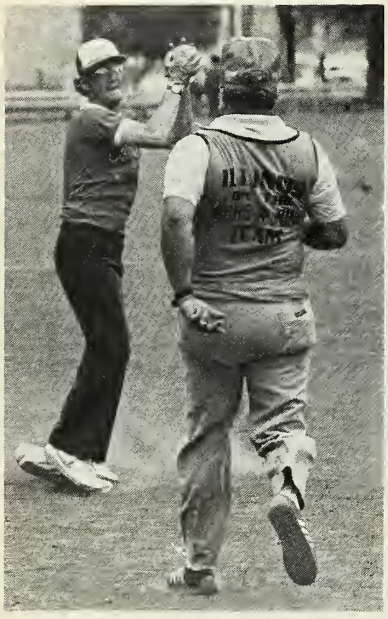
And then the next batter up,
struck out to make the last.



Manager Ted "Casey" Grevas looked worried
as he shuffled through the dirt.



Boyd "Crackin" McCracken hit one,
but then he pulled up hurt.



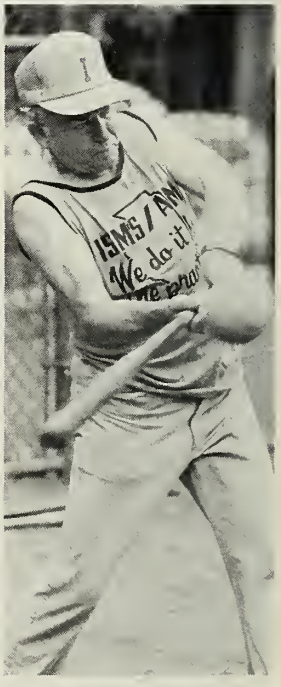
Audley "OJ" Connor came up next,
but out at second was his fate.
And the home team stayed in deep despair
as "Joltin' " Jack Gibbs was nailed at the plate.





But California's next ups were unproductive
as Al "Goose" Goslin spun them in.

And led by Fred
"The Hammer" White,
ISMS came up again.



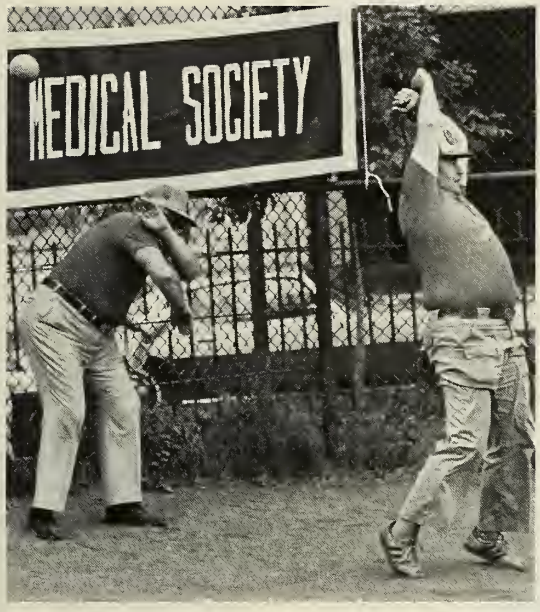
After Harold "Lightning" Lasky's slide,
the score was thirteen-five.





Now was California's time to sweat,
as the Illinoisans came alive.

Morgan "Slugger" Meyer hit one long,
'twas a mighty clout.



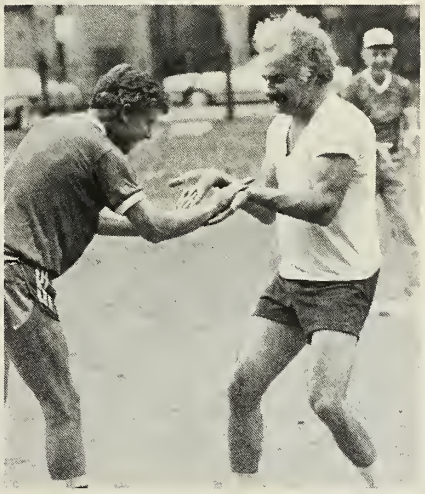


And safe at home was he, when a wild throw
took Bob "Ump" Hartman out.

Hit followed hit, but soon
there were two down

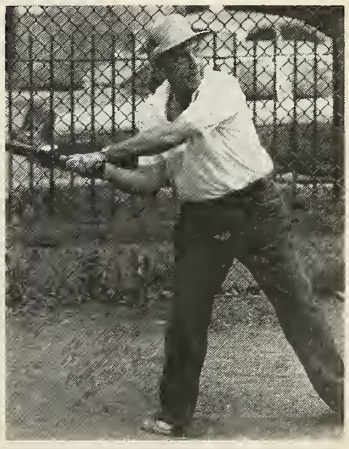


Tension filled the noontime air,
the next pitch meant the crown.





And the field went up for
grabs, as California won
the cup.



And there is no joy in the Prairie State
Since "Mighty" Morrie Friedell popped it up.

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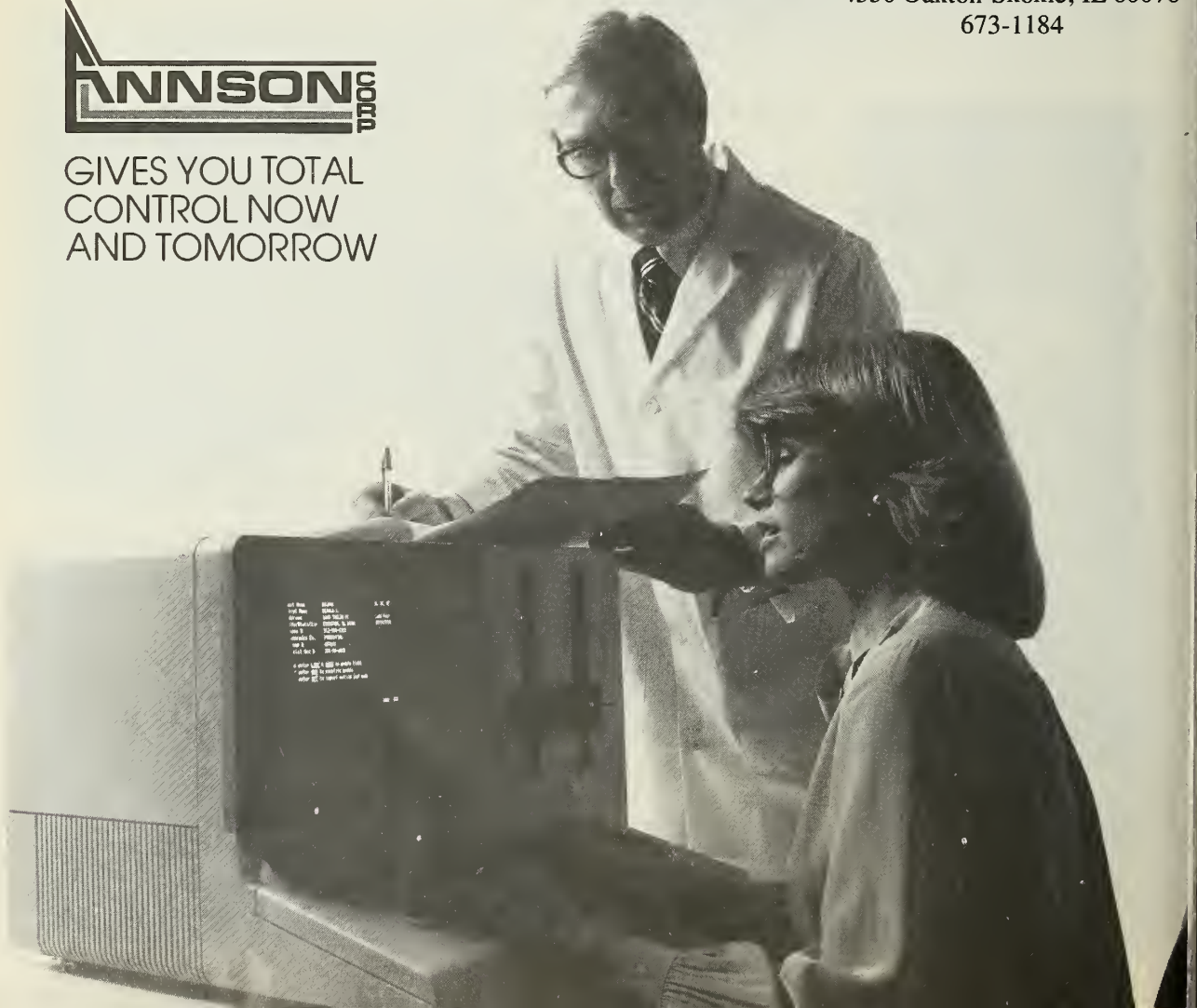
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IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

Dear Colleague:

I am sometimes amazed that the very members of our profession who bemoan the ever-increasing government intrusion into our ability to practice medicine are the same physicians who don't join IMPAC and constantly wonder what possible good IMPAC could do them. Each time a "bad bill" passes, I wonder whether it might have been defeated if these same physicians were involved in the political process. Each time a "bad bill" is defeated, I wonder if the task might have been easier if just one more physician had contacted his legislator regularly and had developed a personal one-to-one relationship.

While I can't make a direct correlation between physician involvement and the defeat of any legislation harmful to medicine, I can assure you, were it not for the involvement of your fellow physicians from across the state, many such bills would be law today. It's a frightening thought for our profession and our patients as well.

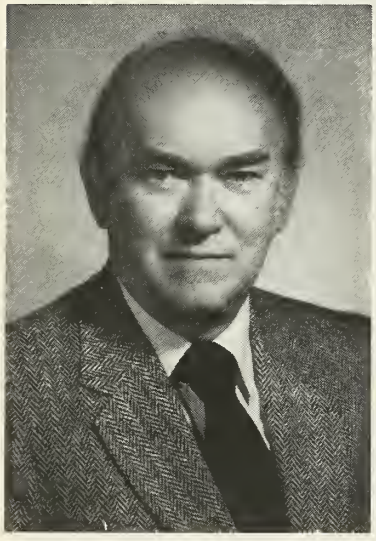
Physician political involvement through IMPAC doesn't guarantee a vote in support of medicine's position. It does guarantee, however, that a legislator will be willing to listen to our perspective. Frequently that willingness to listen is all that is required.

P.F. Mahon MD

Paul F. Mahon, M.D.
Chairman
IMPAC

Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, &110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

President's Page



Nature And Society Abhor A Void

There is a mood of tempered euphoria in the medical community as we anticipate the demise of HSAs and PSROs.

HSAs rapidly are moving toward extinction, and PSROs—without federal funds to sustain them—soon will follow a similar course. Because of HSA activities and some PSRO initiatives, a degree of euphoria is warranted as these organizations fade from the scene. But the euphoria may be somewhat muted by the realization that their demise will create a vacuum.

Planning will, and should, continue. In an era of finite resources, haphazard growth cannot be permitted. The question becomes: What is the best approach to planning?

The top-to-bottom process illustrated by HSAs' adherence to national guidelines was not acceptable. On the other hand, the purchasers of equipment and hospitals will insist on knowing their money is spent prudently. Perhaps new planning blueprints will be dictated by industry and insurance carriers, or even a central government agency.

It seems imperative that organized medicine seize the management responsibility and lead that planning process. If we refuse to participate, we again risk losing not only the initiative but also a voice in decisions that affect our future.

Like HSAs, PSROs face a bleak and limited future. Recently, the statewide Professional Service Review Council ceased operations due to a lack of funding.

We cannot object to accountability. Physicians simply are confronted with the dilemma of identifying who they are accountable to, and under what terms. We must decide if we will be part of the review process through existing physician-directed, sponsored and implemented review organizations . . . or refuse to undertake the responsibility and allow others to assume it. In parts of Illinois where private review is occuring, there is a mechanism that could be adapted for review of government-funded patient care (Medicare, Medicaid).

Society surely will follow the laws of nature and fill the planning void created by the demise of HSAs, and government demands for accountability will require review of patient care which it purchases. Should we in organized medicine recognize that the vacuum will not continue and begin an initiative in planning and review? ◀

Fred Z. White, M.D., President

SEPTEMBER

Hypnosis

Workshops on Clinicol Hypnosis
For: MD's. Workshop, Sept. 17-20, St. Louis, MO. **Sponsor:** American Society of Clinicol Hypnosis, Education and Research Foundation, 2400 E. Devon Ave., Suite 218, Des Plaines 60018. **Fee:** $295. **Reg. limit:** none. **Credit:** Category 1, 25 hours; AAFP Elective, 25 hours. **Contact:** William Hoffman, Jr. **Phone:** 312/297-3317.

Infectious Diseases

Infectious Diseases
For: Primary Care Physicians. Course, Sept. 17-19, Madison, WI. **Sponsor:** CME, U of Wisconsin-Extension, 4658 WARF Bldg., 610 Walnut St., Madison, WI. **Fee:** yes. **Reg. limit:** 180. **Credit:** pending. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Internol Medicine

Internol Medicine of the 1980's
For: Internists, FP's, GP's. Workshop, Sept. 21-23, Chicago. **Speaker:** Ruy Lourenco, MD. **Sponsor:** U of I, CME, 1853 W. Polk St., Rm. 144, Chicago 60612. **Reg. deadline:** 9/7. **Reg. limit:** 200. **Fee:** $250. **Credit:** Category 1, 18 hours; AAFP Elective, 18 hours. **Contact:** Sue Korienek. **Phone:** 312/996-8025.

Medicine

Clinical Refresher Course
For: GP's. Course, Sept. 23-26, Chicago Marriott Hotel. **Sponsor:** Chicago College of Osteopathic Medicine, 5206 S. University Ave., Chicago 60615. **Reg. deadline:** 9/22. **Fee:** $200. **Reg. limit:** none. **Credit:** AOA, 21 hours. **Contact:** Marie Kowalsky. **Phone:** 312/947-4600.

Medicine

Office Dermatology
For: MD's. Symposium, Sept. 29, 7:00 p.m., Vandalia. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Advance Life Support Other Thon ACLS
For: MD's. Symposium, Sept. 26, Ina. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

New Advances in Cardioc Emergencies
For: MD's. Symposium, Sept 23, 6:00 p.m., Wood River. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711

Medicine

Stroke Symposium
For: MD's. Symposium, Sept. 23, 1:00 p.m., Nashville. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Perinotal Workshop
For: MD's. Symposium, Sept. 18-19, Springfield. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. Reg. limit: none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Nucleor Cordiology

6th Annual Nuclear Cardiology Symposium
For: MD's. Conference, Sept. 23-26, Milwoukee, WI. **Sponsor:** CME, U of Wisconsin-Extension, 4658 WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** pending. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Neurology

Common Neurologicol Disorders
For: MD's. Symposium, Sept. 25-26, Pheasant Run, St. Charles. **Speaker:** John Garvin, MD. **Sponsor:** DuPage County Medical Society, 26 W. St. Charles Rd., Lombard 60148. **Reg. deadline:** 9/18. **Fee:** $20.00. **Reg. limit:** none. **Credit:** Category 1, 9 hours; AAFP Elective, 9 hours. **Contact:** Lillian Widmer. **Phone:** 312/495-4050.

Pediotric Neurology

Pediatric Neurology in Doily Clinicol Practice
For: MD's. Seminar, Sept. 30, Maywood. **Sponsor:** CME, Loyola University of Chicago, Stritch School of Medicine, 2160 S. First Ave., Maywood 60153. **Fee:** $125. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours. **Contact:** Linda Gunzburger, PhD. **Phone:** 312/531-3236.

Pediotrics

Seminor in Pediatrics
For: Pediatricians, Primary Care Physicions. Symposium, Sept. 11-12, Madison, WI. **Sponsor:** U of Wisconsin, Dept. of Medicine, 600 Highland Ave., Madison, WI 53792. **Fee:** yes. **Reg. limit:** none. **Credit:** pending. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Surgery

Treatment of Hemorrhagic Shock in Trauma & Surgery
For: MD's. Lecture, Sept. 3, 7:00 p.m., Davenport, IA. **Speaker:** Charles Rice, MD. **Sponsor:** Mississippi Valley Regional Blood Center, 3425 E. Locust St., Davenport, IA 52803. **Fee:** $15.00. **Reg. limit:** 100. **Credit:** Category 1, 2 hours; AAFP Prescribed, 2 hours; AOA, 2 hours. **Contact:** Patricia Harrod.

Surgery

Acute Hand Injuries
For: MD's. Seminar, Sept. 19, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $75.00. **Reg. limit:** 130. **Credit:** Category 1, 7 hours; AAFP Prescribed, 7 hours; AOA, 7 hours. **Contact:** Loretta Giocoletto. **Phone:** 314/454-3873.

OCTOBER

Cordioc Rehobilitotion

Comprehensive Cardiac Rehabilitation Workshops
For: Primary Care Physicians. Workshop, October 12-26, La Crosse, WI. **Sponsor:** La Crosse Exercise Program, Workshop Unit, Mitchell Hall, University of WI, La Crosse, WI 54601. **Fee:** $450. **Reg. limit:** 50. **Credit:** Category 1, 38 hours; AAFP Prescribed, 43 hours. **Contact:** Dr. Philip Wilson. **Phone:** 608/785-8686.

Emergency Medicine

A Postgraduate Institute for Coreer Emergency Physicians
For: Emergency Physicians. Symposium, Oct. 12-16, Detroit, MI. **Sponsor:** Wayne State University School of Medicine, CME, 98-32 DRHUHC, 4201 St. Antoine, Detroit, MI 48201. **Fee:** $500. **Reg. limit:** 20. **Credit:** Category 1, 35 hours; ACEP, 35 hours. **Phone:** 313/577-1180.

Medicine

Psychiatry Update: A Symposium for Physicians and Mental Health Professionals
For: MD's. Symposium, Oct. 28, Springfield. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

OB/GYN Symposium
For: MD's. Symposium, Oct. 29, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Medicine

Professional Burn-Out Symposium
For: MD's. Symposium, Oct. 22, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Management of the Burned Patient
For: MD's. Symposium, Oct. 21, 8:00 a.m., Belleville. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

8th Annual Family Practice Review
For: MD's. Symposium, Oct. 9-10, Springfield. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Appropriate Antibiotic Usage
For: MD's. Symposium, Oct. 8, 1:00 p.m., Pittsfield. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Neurology

Neurology Conference
For: MD's. Lecture, Oct. 10, 8:00 a.m., Iowa City, IA. **Sponsor:** UI College of Medicine, CME, 285 Med Labs, Iowa City, IA 52242. **Fee:** yes. **Reg. limit:** 200. **Credit:** Category 1, 4 hours. **Contact:** R. M. Caplan, MD. **Phone:** 319/353-5763.

Ophtholmology

Ophtholmology for the Primary Care Physician
For: Primary Care Physicians. Symposium, Oct. 9, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** pending. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Orthopedics

Symposium on Sports Medicine
For: MD's. Symposium, Oct. 2, 9, 16, 23 & 30, 11:00 a.m., Oak Park. **Sponsor:** CME, Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Credit:** Category 1, 5 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

Osteoporosis

Osteoporosis
For: Primary Care Physicians. Conference, Oct. 30-31, Madison, WI. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Fee:** yes. **Reg. limit:** none. **Credit:** pending. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Urology

Urology Postgraduate Conference
For: MD's. Symposium, Oct. 2-3, Iowa City, IA. **Sponsor:** UI College of Medicine, CME, 285 Med Labs, Iowa City, IA 52242. **Fee:** yes. **Reg. limit:** none. **Credit:** Category 1. **Contact:** R. M. Caplon, MD. **Phone:** 319/353-5763.

A/V's for CME

The National AudioVisual Center has issued a new catalog of selected audiovisual material suitable for a variety of continuing education uses—individual study, "trigger" for group discussion, demonstration of procedures, etc. Included are 16mm films, videocassettes, audio/slide sets, film strips, and multimedia kits—all available for purchase or rental.

For details, request "Medicine 1981" from . . .

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Doctor's News

ERRATA—In the May *IMJ* Annual Meeting highlights, a photo caption from the ISMS Past Presidents' Dinner included an error. Doctor Edward W. Cannady was identified as Doctor Harlan English in that photo, which appeared on page 302. Doctor English was not able to attend the Past Presidents' Dinner. The *Journal* apologizes for this error.

PHYSICIANS IN THE NEWS—Several ISMS members were elected to national posts at the recent AMA meeting in Chicago. **Joseph H. Skom, M.D.,** Chicago, former ISMS president, was elected to a three year term on the AMA Council on Scientific Affairs and **Ira Friedlander, M.D.,** Chicago, was named resident member of that Council. **L. Ann Nunnally, M.D.,** Chicago, will serve as resident member of the AMA Council on Medical Education. **David Olive, M.D.,** Evanston was elected vice chairman of the AMA/Resident Physician Section and **David Aizuss, M.D.,** Northbrook, was named a member-at-large of that group. **Ron Davis,** Chicago, will serve on the AMA/Medical Student Section Governing Council.

David S. Forkosh, M.D., Evanston, has been elected secretary-treasurer of the American Academy of Medical Directors. Dr. Forkosh is medical director of Forkosh Memorial Hospital. Newly elected directors-at-large for the Chicago Foundation for Medical Care are **Andrew J. Brislen, M.D., William J. Cahill, M.D.,** and **Clifton L. Reeder, M.D.** Directors named to represent specific areas are **Lawrence L. Hirsch, M.D., Francisco Mariano, M.D.,** and **Sylvan D. Solarz, M.D.**

Newly elected officers of the MacNeal Memorial Hospital medical staff are **Robert Novak, M.D.,** Riverside, president, **Miles Cermak, M.D.,** Berwyn, vice president and **George Buckun, M.D.,** Hinsdale, secretary.

At Edgewater Hospital in Chicago, newly elected medical staff officers are **Jerome Goldflies, M.D.,** president; **Regelio Riera, M.D.,** vice president; **Bernard Cohler, M.D.,** secretary/treasurer and **Joseph Silverstein, M.D.,** executive secretary.

Robert E. Lee, M.D., Ph.D., is the newly named vice president of the Illinois Society of Cytology. Dr. Lee is associated with Lutheran General Hospital in Park Ridge. . . . **Daniel X. Freedman, M.D.,** chairman of the department of psychiatry at the University of Chicago is the new president of the American Psychiatric Association. . . . **Hassan Najafi, M.D.,** Chicago, has been named president-elect of the Society of Thoracic Surgeons, an international professional group. Dr. Najafi is affiliated with Rush-Presbyterian-St. Luke's Medical Center.

Robert A. deVito, M.D., Maywood, has been elected president of the Illinois Psychiatric Society. Chicago psychiatrists **Edward Wolpert** and **Patti Tighe** have been elected president-elect and secretary, respectively. Newly named IPS Councilors-At-Large are **Drs. Leon Diamond, David Hawkins** and **David Rothstein,** all of Chicago. IPS also named **Jerome Beigler, M.D.,** Chicago, **Melvin Prosen, M.D.,** Chicago and **Joseph Flaherty, M.D.,** Evanston, to serve as their representatives to the American Psychiatric Association.

MEDICAL STAFF LEADERSHIP SEMINAR ANNOUNCED—The AMA is sponsoring a two day conference on hospital medical staff leadership at the Chicago Drake Hotel, September 18-19. The program, intended to explore physician functions, duties and responsibilities in relationship to the hospital, provides information regarding organization, the art of negotiating, accreditation clinics, quality assurance and other issues. Seminars are scheduled for 8:00am-4:00pm each day, and hour-for-hour Category 1 CME credit is available to participants. Tuition is $250 for AMA members and $375 for non-members. (Additional registrants from the same hospital, including trustees and administrators, may attend at one-half the tuition they would otherwise be required to pay.) Further information may be obtained by writing the Department of Hospitals and Health Facilities, American Medical Association, 535 N. Dearborn, Chicago, IL 60610.

NUTRITION CONFERENCE ANNOUNCED—The American Society for Parenteral and Enteral Nutrition will sponsor a postgraduate course entitled "Advances in Clinical Nutrition," on September 3 and 4 at the Sea Pines Resort, Hilton Head, South Carolina. The course is designed for professionals in the clinical health care field. Further information may be obtained by writing Julie Bishop, A.S.P.E.N., Suite 810, 1025 Vermont Avenue, NW, Washington, D.C., 20005.

EKG

(Continued from page 9)

Answers: 1. C, D 2. B, C, D

Each of the three panels shows sinus rhythm in short runs, *e.g.,* beats 3, 4, 5, 6, 11 and 12 in the top ECG strip. There is slight sinus arrhythmia here at a rate of 90 beats per minute. These groups of sinus beats are separated by beats with a distorted P wave or no P wave at all at a rate of 52 beats per minute. These are junctional escape beats or junctional rhythm and are best seen as beats 2, 3, 4, 8, 9 and 10 in the last ECG strip. When the sinus fails, these junctional beats keep the ventricle stimulated and the patient maintains his blood pressure. This is an example of sinus arrest or high grade sino-atrial block. Even though the P-P cycles are not equal, there is failure of sinus impulse formation allowing the subsidiary junctional pacemaker to escape. This is commonly caused by digitalis intoxication. Both digoxin and quinidine were discontinued because of the interaction of these two drugs. The patient was hospitalized for ECG rhythm monitoring and had a serum digoxin level drawn. Serum digoxin concentration was abnormally elevated. Some studies have demonstrated that patients on digoxin can double their serum digoxin concentration by taking quinidine in addition. The time course of the drug interaction here was longer than might be anticipated. Still, the cause of this arrhythmia was digoxin intoxication. Discontinuing the drugs allowed normal sinus rhythm to return. No pacemaker was required because the rate never fell below 45 beats per minute and no symptoms of bradycardia were seen.

For more information on digoxin-quinidine interaction, see Doering, *New England Journal of Medicine,* 301:400, 1979; Bigger, *New England Journal of Medicine,* 301:779, 1979, and Hirsch, *et al., American Journal of Cardiology,* 46:863, 1980. ◀

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Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
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Prolonged or excessive use of corticosteroids might produce systemic effects.
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Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
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Viewbox

(Continued from page 14)

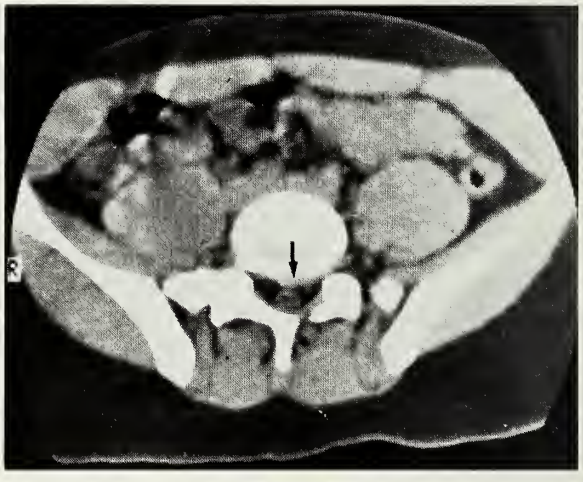


Figure 5

ANSWER: C.T.—Herniated L_5-S_1 disc (arrow, Figure 5).

The merits of the different choices are as follows. Surgery without definitive demonstration of a lesion is not generally recommended. Repeating the myelogram with an oily contrast (Pantopaque) is very unlikely to demonstrate a lesion not demonstrated by water soluble contrast (Metrizamide) because of the former's inherent greater radio-opacity and lesser viscosity. Epidural venography is certainly a useful procedure in symptomatic patients with a negative myelogram, but it is invasive and time consuming. Computed tomography of the spine is currently the best answer. If CT is negative, conservative management would then be recommended.

In this case, however, the CT scan demonstrates a lateral disc herniation at the L_5-S_1 disc level (arrows). The patient was free of symptoms following surgery.

This case demonstrates the significant advance in the diagnosis of lumbosacral disease that CT scanning of the spine represents.[1-6] Prior to the

advent of CT, the myelogram was considered the standard diagnostic procedure of choice in the determination of herniated lumbar disc. CT scanning has, in a short period of time, demonstrated just how inaccurate myelography is. Some sources suggest that there is an approximate 20% false negative rate. In addition many patients who undergo myelography for other reasons have signs of disc disease without appropriate clinical symptoms. This poor specificity of the myelogram has undoubtedly contributed to some of the poor results seen in back surgery.

With the advent of CT scanning, however, a new perspective has developed. Because myelography demonstrates only the subarachnoid space and its contents, lesions or abnormalities not indenting or in contact with it are not demonstrated. This includes lateral disc protrusion, abnormalities of the pathway of the nerve through the intervertebral foramen and degenerative changes in the facet joints. Herniated discs and degenerative facet joint changes often coexist and each may produce backache or nerve root compression, particularly if the disc space has become narrowed, producing stress on these joints.

The facet joint changes are exquisitely shown at CT and this facilitates surgical preplanning.

Since the addition of CT to our diagnostic arsenal, patient selection for surgery and procedural preplanning have resulted in an immediate improvement in short-term outcome.

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

CHICAGO: Family practitioner, dynamic two doctor urban practice. Comprehensive ambulatory emphasis. Nearby hospital privileges include OB. Far south Chicago, ethnic, blue collar community. Spanish desirable. CONTACT: T. Kearney, M.D., Claretian Medical Center, 2945 E. 91st St., Chicago 60617 (312-768-5000). (8)

CLIFTON: Service Area. 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

EDWARDSVILLE: practice opportunity available in area with over 10,000 population near St. Louis, Mo. Two FP planning retirement. CONTACT: J. C. Collins, Jr., M.D., 325 S. Kansas St., Edwardsville 62025. (618-656-1048). (9)

EL PASO: Population 2700. Family Practice available immediately. Fully equipped office. Excellent schools, churches and hospitals. Contact R. P. Lykkebak, M.D., El Paso 61738. Phone (309) 527-4007. (9)

FAIRBURY: Thriving family practice opportunity available as third physician of well-established group. Progressive rural community near urban areas. Well-equipped, JCAH accredited, 112 bed hospital offers income guarantees and other financial assistance. Send CV in confidence to: F.A. Brady, Adm., Fairbury Hospital, 519 S. 5th St., Fairbury 61739. (8)

FREEPORT: Otolaryngologist, Cardiologist, Gastroenterologist, General Internist, Family Practice, Urologist—to join expanding 20 physician multi-specialty Clinic. This 30 yr. old group practices in a new facility across from a recently expanded general hospital in a community of 30,000. CONTACT: C. Wm. Metcalf, M.D., Medical Director, Freeport Clinic, S.C., 1036 W. Stephenson St., Freeport 61032, 815-235-5111. (12)

MT. CARMEL: Wanted pediatrician or family practitioner to replace retired physician. Office ready to go. Solo or joint with another physician. CONTACT: B. G. Lambos, M.D., 101 Broad St., Lanark, 61046 (815-273-3323). (8)

PARIS: Practice opportunity available. Physician (FP) planning to retire is interested in someone to take over practice. Population area over 10,000. Modern hospital facilities and complete office available. CONTACT: Dr. G. M. Churukian, 406 S. Main St., Paris 61944. (217-463-4560). (9)

PONTIAC: Associate in my local downtown office building. Great need for qualified Orthopedic Surgeon or Associate in Family Practice. Could be renting separate office or my same large 2-man designed office space. Economic association, partnership or rental could be arranged, mutually. Long-standing 60 year practice established by father. Contact H.C. Parkhill, M.D., 202 N. Main St., Pontiac 61764 or AC 815-844-6148. (9)

SAVANNA: Practice Opportunities—FP's and Internal Medicine Specialists. Join progressive health care center in delightful small town community. Complete office facilities, immediate access to hospital. Financial assistance available. Hunting, fishing, water-sports paradise. CONTACT: Darrell Milner, Savanna/Carroll County Health Services, 333 Chicago Avenue, Savanna, 61074; Phone (815) 273-2287. (12)

WAUKEGAN: Plant Physician Wanted. Responsibilities include services to occupational disease and injury cases, physical examinations, evaluation of disability cases and advising management on medical matters. Excellent benefit package available. Salary negotiable. Please contact J.W. Szeygielski, Employee Relations Manager, Johns-Manville Sales Corp., Greenwood Avenue, Waukegan 60087. (AC 312) 623-2900 EXT 213. (12)

IMJ Attention

POSSIBLE END TO NATIONAL HEALTH PLANNING LAW — The AMA has reported that a bill to repeal PL 93-641, the National Health Planning and Resources Development Act, has been introduced by Congressman Richard Shelby (D-Alabama), a member of the House Energy and Commerce Committee's Sub-committee on Health. HR 3666 is strongly supported by the AMA, and Reagan Administration plans to phase out funding for the program over the next three years are said to support optimism for its passage.

AMA notes that plans to end federal funding do not affect requirements under federal law that states enact conforming certificate of need provisions.

AMA support for rescission of PL 93-641 is based upon five perceived shortcomings in the Act: (1) federal regulations are imposed upon what should be primarily local health planning; (2) short-term cost containment objectives have been targeted over local health needs; (3) the program is not cost effective; (4) plans are anti-competitive and create barriers through CON and other approval requirements and (5) complex regulations growing from the law give undue emphasis to red tape over health care.

FEDERAL HEALTH SPENDING CUT — A budget resolution passed by the U.S. Congress calls for $73.5 billion in federal health spending over the next fiscal year, AMA reports. That figure, which is more than $3 billion less than predicted, has resulted in concomitant cost cutting by House committees.

AMA reports that the House Ways and Means Committee has recommended that the Medicare program be cut by $1.7 billion. One vehicle would make Medicare a "second payer," when retired persons have other health insurance. The committee has also recommended that federal funding for PSRO terminate within two years.

In a similar action, the Senate Finance Committee has recommended Medicare savings through higher deductibles and reduced benefits. That plan would also cut Medicaid spending by $1.1 billion.

DES RESEARCH RESULTS — The National Cancer Institute has published several documents detailing results of the DESAD Project, a five year study of associated vaginal and cervical irregularities, and rare instances of clear-cell adenocarcinoma, occurring in daughters of persons exposed to Diethylstilbestrol *in utero*. Findings also include other health effects, and research of possible effects on male offspring. The summaries include color illustrations of frequent abnormalities and pathological specimens.

Physicians may order copies of *Information for Physicians*, an *Atlas of Findings*, and also patient education booklets entitled *Questions and Answers About DES Exposure During Pregnancy and Before Birth* and *Were YOU or YOUR DAUGHTER or SON Born After 1940?* at no cost. These materials may be obtained by writing the Office of Cancer Communications, Department DES, Building 31, Room 10A19, National Cancer Institute, Bethesda, MD 20205.

CALL TO INVOLVEMENT — Summer months often provide opportunity to pursue interests and hobbies. The ISMS Key Man Program can provide a rewarding and worthwhile outlet for intellectual energies.

The Key Man is either a constituent of a legislator or person who practices in the legislative district. Ideally, he or she is also a relative, personal friend or campaign supporter. The Key Man's responsibility is to advise state legislators and congressmen of ISMS positions on significant bills, and the implications of health-related proposals.

The Key Man is provided with background information and detailed explanation of the ISMS position when important issues come before the General Assembly or Congress. This information is generally supplied through the *On The Legislative Scene* newsletter. Armed with these facts, he contacts his legislator, explains the ISMS position and seeks support for it.

Key Men are not expected to devote extraordinary time commitments. They are contacted by ISMS staff only when major issues arise, and then asked to telephone or write the legislator. Personal travel and meetings are not required.

The Key Man Program has been part of ISMS public affairs activities for over ten years. It provides an opportunity to fulfill civic duty and serve your profession. You might get to know your legislators better during the summer to enhance your role as a Key Man.

Further information about the Key Man Program may be obtained by writing the Illinois State Medical Society, Public Affairs Committee, 55 E. Monroe, Suite 3510, Chicago IL 60603; (312) 782-1654.

CHILD ABUSE PREVENTION — The National Committee for Prevention of Child Abuse (NCPCA) has announced publication of five new educational items which deal with child abuse, child abuse prevention and parenting. New titles are: "An Approach to Preventing Child Abuse," "Physical Child Neglect," "Emotional Maltreatment of Children," "Growth and Development through Parenting," and "Parent-Child Bonding: The Development of Intimacy." The NCPCA catalog, which describes available materials and gives instructions for obtaining them, is available by writing NCPCA, Publishing Dept., 332 S. Michigan Ave., Suite 1250, Chicago IL 60604; (312) 663-3520.

ACIP CONVENTION ANNOUNCED — The sixth annual convention of the American College of International Physicians will be held August 19-23 at the Chicago Lake Shore Hotel, 600 N. Lake Shore Drive, Chicago. The College will consider issues affecting all physicians, but particularly those who were educated in medical schools abroad. Fellowship is open to all physicians who were educated in foreign medical schools and now practice in the United States. Scientific sessions will provide up to 19 hours Category 1 CME credit. Further information may be obtained by writing the ACIP office at 3030 Lake Avenue, Fort Wayne, IND 46805.

HCG TREATMENTS PERSIST — The AMA has reported that, despite lack of any proven efficacy, HCG (human chorionic gonadotropin) is being used in diet clinics throughout the US.

In an evaluation of HCG, (*JAMA*, 1974) two senior AMA scientists analyzed claims made for the product and concluded: "No convincing scientific evidence exists that human chorionic gonadotropin has any pharmacologic effect in weight reduction. Hence, claims to the public that such effects do occur are a misrepresentation of the scientific facts."

The AMA report states that a recent newspaper advertisement listed ten locations for clinics in Chicago alone which use HCG to help the overweight trim off pounds.

The FDA now requires a printed statement in labeling and advertising for all marketed preparations of HCG. Advertisements must state that HCG is not approved by the FDA as safe and effective in treatment of obesity or weight control.

The AMA report concludes: "The claim that HCG causes preferential mobilization of 'abnormal' fat is unsupported by any acceptable scientific evidence. There is no rational basis for its use in weight reduction, except as a placebo."

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REPORT FOR *Illinois Physicians*

FALL WORKSHOP SERIES PLANNED

The Illinois Blue Cross and Blue Shield Plan's Fall Workshop series for medical assistants in the Chicago and Metropolitan areas will begin on September 9. The majority of meetings have been scheduled in the Blue Shield Auditorium at 2 Illinois Center.

The workshops are intended to inform medical assistants in Plan administrative, claims and payment procedures and advise them of changes in Blue Shield benefits and contracts.

Letters of invitation are being sent to physician's office's with reservation forms. For additional information, please write Professional Relations Department, Blue Cross and Blue Shield Plan, 233 North Michigan Avenue, Chicago, Illinois 60601, or call (312) 661-4489.

The following workshops are scheduled:

Wednesday	September 9	Blue Shield Auditorium 2 Illinois Center	9 a.m. to Noon
Wednesday	September 16	Blue Shield Auditorium 2 Illinois Center	1 p.m. to 4 p.m.
Thursday	September 17	Blue Shield Auditorium 2 Illinois Center	9 a.m. to Noon
Wednesday	September 23	Holiday Inn; Gurnee, Ill. 6161 West Grand at Rte. 132	9 a.m. to Noon 1 p.m. to 4 p.m.
Wednesday	September 30	Blue Shield Auditorium 2 Illinois Center	9 a.m. to Noon
Wednesday	October 7	Blue Shield Auditorium 2 Illinois Center	9 a.m. to Noon
Wednesday	October 14	Blue Shield Auditorium 2 Illinois Center	1 p.m. to 4 p.m.
Wednesday	October 14	Joliet Holiday Inn South I-80 at Larkin Road	9 a.m. to Noon
Wednesday	October 21	North Aurora Holiday Inn 311 So. Lincolnway	9 a.m. to Noon 1 p.m. to 4 p.m.
Thursday	October 22	Elgin Holiday Inn 345 West River Road	9 a.m. to Noon 1 p.m. to 4 p.m.
Wednesday	October 28	Blue Shield Auditorium 2 Illinois Center	9 a.m. to Noon 1 p.m. to 4 p.m.
Wednesday	November 4	Blue Shield Auditorium 2 Illinois Center	9 a.m. to Noon 1 p.m. to 4 p.m.
Thursday	November 5	Blue Shield Auditorium 2 Illinois Center	9 a.m. to Noon 1 p.m. to 4 p.m.

NEW MAJOR MEDICAL PLAN AVAILABLE UNDER HIA PROGRAM

A new comprehensive Major Medical Plan, called HIA 500, went into effect in July for Health Improvement Association members.

New members are being given the option of purchasing the HIA 500 Plan, or the present HIA 80 program. The HIA 100 program will no longer be available to new members.

The new identification number for the HIA 500 Plan will retain the regular five-digit group number and five-digit subscriber number, but will have a 1 (one) in front of the group number

Following are benefit highlights of the new program:

— Lifetime Maximum . . . $1,000,000
— Out-of Pocket limitation per person per calendar year . . . $2000 (deductible applies) - maximum two per family
— Dependent unmarried children . . . From birth to age 23
— After a deductible of $500 per person per calendar year has been met (maximum deductibles two per family); the following benefits will be paid at 80 percent.

HOSPITAL BENEFITS

— Inpatient days per accident or illness . . . 365 days
— Room allowance . . . most common semi-private room
— Ancillaries

MEDICAL/SURGICAL BENEFITS

— Inpatient medical visits per accident or illness . . . 365 days
— Surgery, wherever performed
— Obstetrical care
— Anesthesia
— Consultation (in-hospital only)
— Surgical Assistant

NOTE: Payment is based on usual and customary fees.

OUTPATIENT BENEFITS

— Emergency accident and medical care within 72 hours

BENEFIT EXCLUSIONS

— Outpatient mental care
— Chiropractic services

WAITING PERIOD

There is a 270 day waiting period for *all pre existing conditions* including maternity under th Comprehensive Major Medical Plan and the HIA 8(Plan. This waiting period commences on the Cover age Date for any condition existing on the Coverag Date for which treatment has been received within year prior to the Coverage Date. *No benefits will b provided for services related to such condition unti after the expiration of the waiting period.* Thi waiting period is reduced by the length of time com parable coverage was held under any other Blu Cross and Blue Shield benefit contract continuousl providing coverage to the Coverage Date under thes contracts.

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The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contreindiceted: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnency:* Use of minor trenquilizers during first trimester should elmost elweys be evolded beceuse of increesed risk of congenitel melformetions es suggested in severel studies. Consider possibility of pregnency when instituting therepy; edvise petients to discuss therepy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
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Clinics for Crippled Children Listed for September

Forty-one clinics for Illinois' physically handicapped children have been scheduled for September by the University of Illinois, Division of Services for Cripped Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 30 general clinics, 10 cardiac clinics, and one for children with neurological problems. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

1 Carrollton—Boyd Memorial Hosp.
1 Belleville—St. Elizabeth's Hospital
1 Park Ridge Cardiac—AM—Lutheran General Hospital
1 Park Ridge General—PM—Lutheran General Hospital
1 Wheaton General—Marianjoy Rehab. Hosp.
2 Hinsdale—Hinsdale Sanitarium
3 Sterling—Community General Hospital
3 Effingham—St. Anthony Memorial Hosp.
3 Lake County Cardiac—Victory Memorial
4 Division Cardiac—U. of I. at the Medical Center
8 East St. Louis—Community Hospital
8 Peoria—St. Francis Medical Center
9 Rock Island CP—Foundation for Crippled Children & Adults
9 Carmi—Carmi Township Hospital
9 Champaign—Urbana—McKinley Health Service Center
9 Joliet—St. Joseph's Hospital
9 Chicago Heights General—St. James Hospital
10 Aurora Cardiac—Mercy Center for Health Care Services
10 Kankakee General—St. Mary's Hospital
14 Peoria Cardiac—St. Francis Med. Center
14 Chicago Heights Cardiac—St. James Hosp.
14 Maywood—(Ortho/Ped/Neuro)—Loyola Medical Center
15 Rock Island General—Moline Public Hosp.
15 Alton—Alton Memorial Hospital
15 Decatur—Decatur Memorial Hospital
16 Springfield Ped—Neuro—St. John's Hosp.
16 Evergreen Park—Little Company of Mary Hospital
17 Rockford—Rockford Memorial Hospital
17 Springfield—St. John's Hospital
17 Centralia—St. Mary's Hospital
17 Elmhurst Cardiac—Memorial Hospital of DuPage County
18 Kankakee Cardiac—St. Mary's Hospital
21 Maywood—(Ortho/Ped)—Loyola Medical Center
22 Peoria—St. Francis Medical Center
23 Chicago Heights General—St. James Hosp.
24 Macomb—McDonough Health Department
24 West Frankfort—United Mine Worker's of America—Union Hospital
28 Peoria Cardiac—St. Francis Med. Center
28 Chicago Heights Cardiac—St. James Hosp.
28 Maywood—(Ortho)—Loyola Medical Center
30 Elgin General—Sherman Hospital

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology, Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Edward Chesna, M.D., radiology department, Loyola University Medical Center.

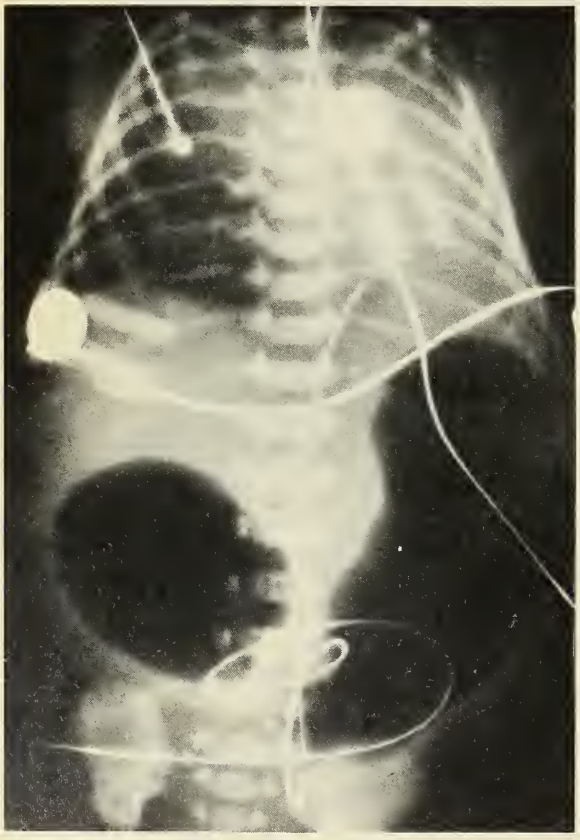


Figure1—Patient 1
This neonate presents with vomiting in the first 24 hours of life.

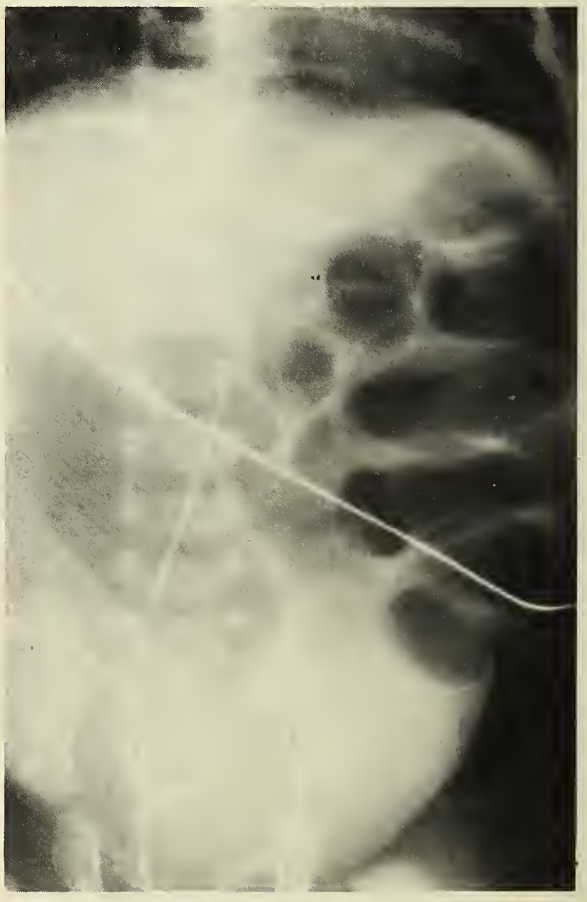


Figure 2— Patient 2
This neonate has had intermittent episodes of vomiting during the first week of life. The abdomen is flat.



Figure 3—Patient 3
This neonate presents with abdominal distention.



Figure 4—Patient 4
This neonate had normal passage of meconium, but now presents with vomiting and abdominal distention.

What diagnosis fits each plain film picture best?

a) Midgut volvulus
a) Jejunal atresia
c) Meconium peritonitis
d) Duodenal atresia

(Continued on page 117)

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Guest Editorial

Prepaid Health Care in the United States

By Stuart S. Burstein, M.D./Chicago

Prepaid health care has evolved, through contract medicine, industrial medical services and government, to subsidized medical care. It is currently expanding with HMOs. HMOs are organizations which provide medical care. Their cost containment programs could influence federal legislation related to national health insurance and mandatory cost controls. HMO membership activities may have an effect on the potential for malpractice complaints.

Prepaid health care has received much attention from organized medicine, the federal government and the general public. It is not a new arrival on the health care scene. Forms of prepaid medical care have been practiced in the United States since the founding of the country. Industry and labor have favored some form of prepaid medical care for over 50 years. The medical care of active duty and retired military personnel and their dependents has been the equivalent of a prepaid system for many years.

Within the U.S., prepaid health care reflects the industrial expansion and governmental intervention which have occurred in the nineteenth and twentieth centuries. Health Maintenance Organizations (HMOs) are the most recent form of prepaid health care. They epitomize what Peter Drucker foresaw 40 years ago to the effect that "any organization—is as much a social organization, a community and society, as it is an economic organ." Drucker has spoken of "industrial citizenship;" it would be appropriate to speak of "organizational citizenship" for HMOs.

Prepaid health care was first practiced in the U.S. as "contract medicine." Contract medicine arose in the south before the Civil War. It generally was practiced by young physicians who had difficulty establishing a practice or collecting a fee. They contracted with plantation owners to provide medical care. Through the contractual arrangement, the physicians gained both experience and income. An early instance of contract medicine occurred when George Washington and his fellow plantation owners hired physicians to care for their slaves.

The contract system spread to urban areas, where young practitioners offered flat, annual rates to members of labor unions, social organizations and other groups. Competition among physicians not only assured their availability for contracts but kept contract fees minimal. The contract form of medical practice dwindled to negligible proportions by the 1920s.

Another early form of prepaid health care in the U. S. was the railroad medical service. Such services began to develop in the late nineteenth century, when railroads spread across the country.

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As the railroads advanced into remote areas and the number of employees grew, it became necessary for management to provide medical services which were covered by deductions from the worker's pay. The railroad company became responsible for employing salaried physicians to care for workers and their dependents. In many cases, the company developed hospitals for its employees.

Subsequently, a development similar to railroad medical services occurred in the mining and lumber industries. The Kaiser-Permanente Health Plan began in part with a mining company medical service. Kaiser Industries was one of the companies building Hoover Dam in the 1930s. It was responsible for the health of its employees. They were far from any regularly-available medical facilities. However, there were some physicians working for a nearby mining company. Kaiser hired these physicians as the nucleus of a medical group to look after the needs of the workers.

From this beginning, Kaiser went on to provide similar medical care for its workers in the shipbuilding industry and other government-financed construction projects on the west coast during World War II. The projects were often located in remote areas. Numerous construction workers and their dependents required basic medical care. Kaiser's medical group provided the care, and financing came from the government's support of the projects. Thus, the largest prepaid health plan in America developed from medical care that started with indirect subsidies from the federal government.

The success of the Kaiser Plan gave impetus to prepaid group practices in the years following World War II. Some prepaid plans were developed by individual labor unions, often in cooperation with employer associations. Others were established as community health associations with the support of both labor and industry. These usually aimed to provide high-quality medical care at reasonable cost.

Concern for costs has regularly been a consideration in plans for prepaid care. A federal project entitled "Committee on the Costs of Medical Care" first laid out the idea of a prepaid national health service in 1932. The plan was designed as a nationwide service which would be paid for by contributions from employers, employees and the federal government. It closely paralleled the lines of an HMO.

More Recent History

The passage of Medicare in 1965 brought the federal government into direct subsidization of health care. By 1970, it was apparent that the costs of health care were rising dramatically: the national expenditure for health care in 1975 was $119 billion. This was ten-fold the amount for health care in 1950 and five-times the amount in 1960. Prepaid health care was seen as a means to control the cost of health care.

On March 23rd, 1970, nearly 40 years after the federal Committee on Costs of Medical Care recommended a prepaid health plan, the term "Health Maintenance Organization" first made a public appearance. Its debut occurred before the House Ways and Means Committee to which the Nixon Administration was presenting its "Health Effectiveness Bill." Two days later, Department of Health, Education and Welfare Secretary Finch suggested the concept of an HMO as a new approach to providing Medicare benefits.

An additional three years of hearings, legislative efforts and politicking preceded the passage of the HMO Act of 1973. That act provided enabling legislation to facilitate the development of HMOs across the country.

There were only 20 prepaid health plans existing in the U.S. before 1960. There are over 200 today with a total membership of 9.0 million people. In the Metropolitan Chicago Area there are six federally-qualified HMOs with a combined membership of approximately 195,000 which is 2.5% of the Metropolitan Chicago population. Current projections hold that 20 million persons (10% of the U.S. population) could be covered by HMOs in the next five years.

The Federal HMO Act of 1973 established the HMO as an organized health care delivery system that provides a wide-range of comprehensive health care services to a voluntarily enrolled population in exchange for a fixed and prepaid periodic payment. The act provided grants and loans for planning and development. It overrode restrictive state laws and mandated dual choice for employers of 25 or more employees. Within the HMO, emphasis is placed on ambulatory care and preventive service. Such emphasis is part of an effort to maintain the health of the enrollees and minimize inpatient care.

HMOs arrived on the health care scene in late 1973. They have subsequently expanded in number and size. They are federally-mandated as a health care option for many Americans and have considerable importance for organized medicine. In particular, HMO cost containment programs could influence federal legislation for national health insurance and mandatory cost controls. HMO membership activities may contribute to those organizations' comparatively small experience with malpractice claims.

Economic Aspects

HMOs are likely to influence federal health care legislation through their cost containment programs. They hold down costs by minimizing hospital-bed utilization. They provide further incentives for cost control with the capitation method of payment.

Cost containment is attractive to government officials who want to implement some form of national health insurance. National health insurance is deemed risky until a lid is put on the rising cost of health care. HMOs are a means to hold down the cost of health care. Thus, they provide financial safeguards which encourage congressmen and the executive branch to proceed with plans for national health insurance.

On a different note, cost containment could discourage the movement for mandatory cost controls. Organized medicine has responded to the threat of mandatory cost controls with an emphasis on voluntary cost control. HMO cost containment promotes voluntary cost control by encouraging competition within the health care system. Competition fosters price consciousness on the part of providers and consumers. It thereby should help stabilize costs of medical care. Stabilization of costs supports the voluntary effort for cost control and consequently erodes the federal government's argument for mandatory cost controls.

There are reports of closed-panel HMO staffs experiencing a lower incidence of malpractice claims in comparison to similar groups of fee-for-service M.D.s or university hospital staff physicians. The membership activities of closed-panel HMOs could be a reason for their comparatively small experience with malpractice claims. The closed-panel HMOs acquaint members with their programs through marketing efforts and periodic newsletters. They encourage members to select a primary-care physician and to utilize preventive medical services. They frequently have consumers on the board of directors. Thus, the closed-panel HMOs facilitate member participation in the organization. Participative membership may decrease the potential for malpractice complaints.

In summary, prepaid health care has evolved in association with industrial expansion and federal intervention. At the present time, it is most widely practiced through HMOs. HMOs may influence health care legislation by encouraging cost control and competition. They may also have an effect on the potential for malpractice complaints.

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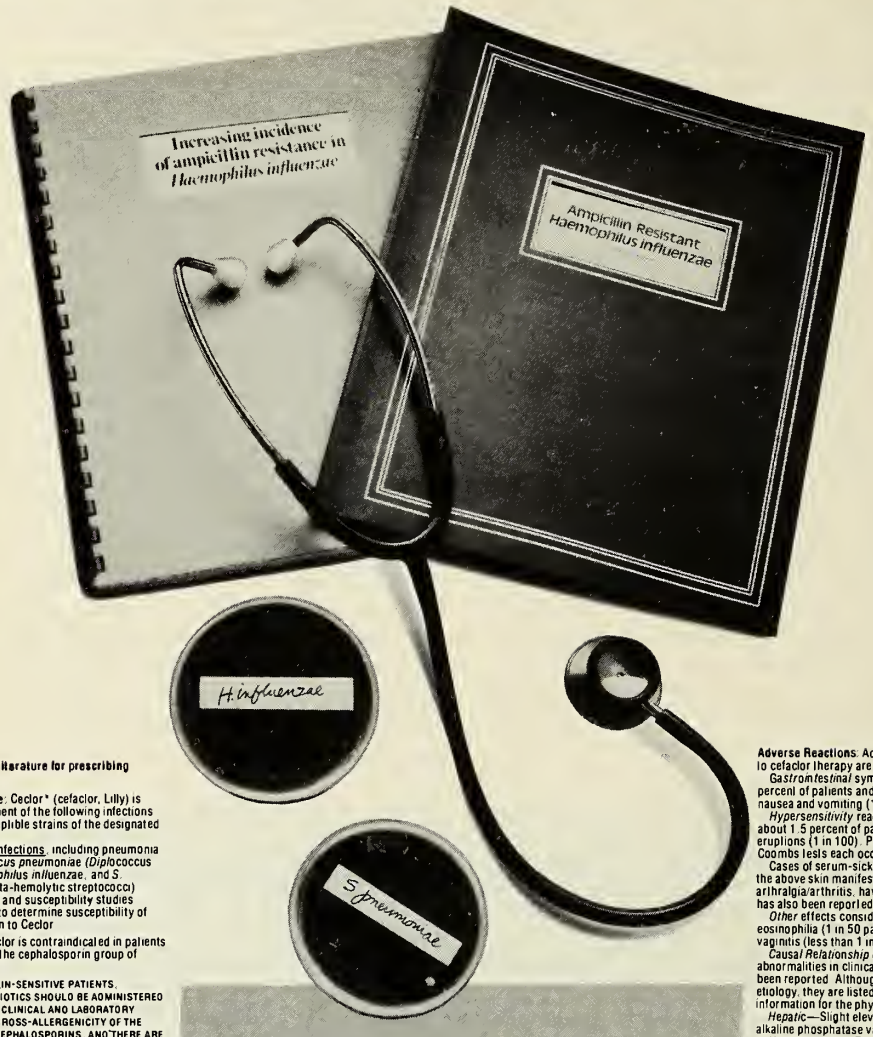
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Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae,* and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

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Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae.*

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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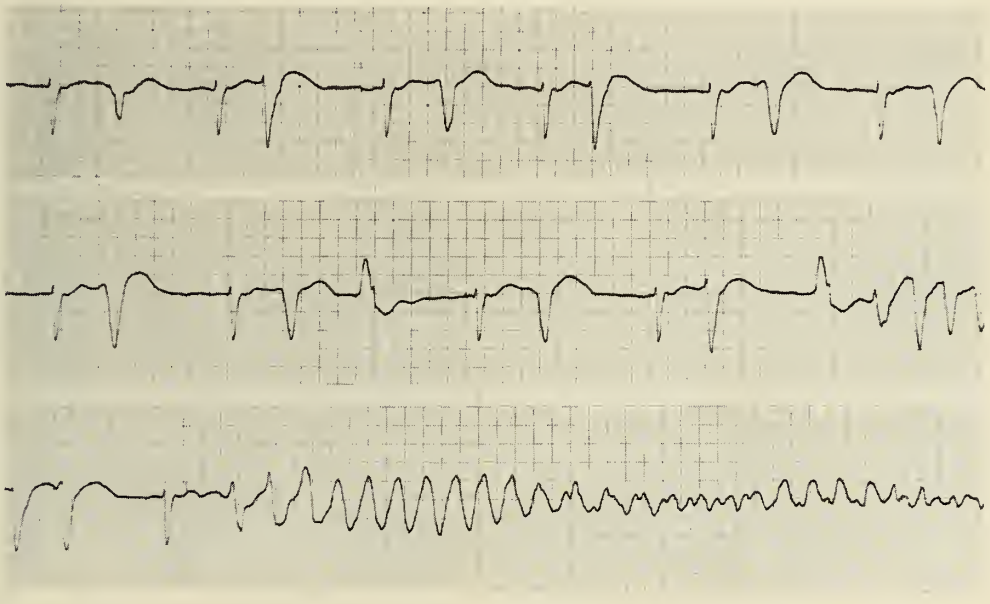
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100061

EKG of the Month

This is an eighty-one year old man who gave a two to three month history of exertional and postprandial chest pressure. It was associated with shortness of breath and dizziness. A previous problem of congestive heart failure had been treated with digoxin, furosemide, and potassium chloride. There was a question of poor compliance in taking medication, and this was partly confirmed with a nondetectable serum digoxin level. Physical examination demonstrated bilateral crepitant rales in the lung bases, and atrial and ventricular gallops. A chest X-ray showed cardiomegaly with bilateral pleural effusions. An ECG showed complete left bundle branch block. The patient was hospitalized and no myocardial infarction was found. His congestive heart failure improved and he was discharged from the hospital.

Three months later he was readmitted to the hospital with shortness of breath. He was again in congestive heart failure, but there was no history of chest discomfort or dizziness. However, the ECG now showed atrial fibrillation, complete left bundle branch block, and frequent premature ventricular beats. A serum digoxin level was in the therapeutic range. An increase in diuretic therapy improved the patient's heart failure. The premature ventricular beats were treated with 800mg. of quinidine sulfate per day and seemed to be decreasing in frequency. A twenty-four ambulatory ECG Holter was ordered to evaluate the anti-arrhythmic therapy. A portion of this ECG recording is shown.



Questions:

1. **The ECG rhythm strip shows:**
 a. Atrial fibrillation.
 b. Multifocal premature ventricular beats.
 c. Bigeminy.
 d. Ventricular flutter-fibrillation.
 e. All of the above.
2. **Which of the following statements are true?**
 a. The incidence of premature ventricular beats tends to increase with age, along with the increased incidence of coronary artery disease.
 b. The significance of ectopic ventricular beats seems to be related to the underlying presence or absence of organic heart disease.
 c. Left ventricular tachycardia is more often associated with organic heart disease than is right ventricular tachycardia.
 d. In the presence of coronary artery disease, left ventricular aneurysm is a common anatomic basis for ventricular tachycardia.
 e. All of the above.

(Continued on page 130)

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A Partial Solution to Early Lead Failures

The Tined Transvenous Pacing Lead

By Donald M. Coder, M.D., V. Arvind Menon, M.D.,
Adam H. Romeiser, Jr., M.D., Mark A. Stern, M.D.,
And James M. Wicks, M.D./Highland Park And Lake Forest

Displacement of a transvenous electrode in the first few hours or days after placement has caused a high incidence of repeat surgery. This incidence ranges from a low of around 4% to 20% or more. Even centers with a large experience have reported early repeat surgery for lead complications in 20% or more of new pacemaker implantations.[1-5] One approach to reducing the incidence of early dislodgment has been development of new lead systems with devices designed to hold the lead in the intended position. The screw-in myocardial electrode was developed largely to avoid entirely the problem of dislodgment with transvenous leads. More recent innovations in transvenous leads have been directed toward ways of attaching the lead to trabeculations or the endocardial surface. These include hooks, barbs, jaws, screws, an inflatable balloon, a wedge-shaped flange, a porous tip, nylon barbs, and soft tines of various lengths.[6]

In 1978, we first began using a lead with 2.5mm. silicone rubber tines. This review of our early experience with this lead compares it with the flanged lead, which we had employed routinely since 1974. A combined total of 72 consecutive cases is reviewed.

Procedure

The hospital records of 72 consecutive patients were reviewed. All had implantation of a permanent transvenous cardiac pacemaker during the period from March, 1976 through August, 1979. The flanged lead was employed in 33 patients and the tined lead in 39 patients. The procedures were performed in the operating room under local anesthesia. The cephalic vein was the intended route of entry into the venous system in each case. Electrical parameters were measured intraoperatively using a pacing system analyzer. The patient was monitored a minimum of 48 hours and was kept in bed for this period. Discharge from the hospital was permitted on the fifth postoperative day whenever possible, but most patients remained in the hospital for seven to eight days. Subsequent monitoring of pacemaker function was by telephone-transmitted EKG or by office-based EKG. Follow-up was for a minimum of one month.

TABLE 1
Electrical Parameters Measured Intra-Operatively

	Flanged Lead	Tined Lead
Voltage Threshold, volts	0.75 (0.08)	0.59 (0.04)
Resultant current, milliamperes	1.07 (0.08)	0.89 (0.06)
Impedance, ohms	587 (2.4)	581 (18.5)
R-wave, millivolts	8.1 (0.56)	9.70 (0.78)

Means, with standard error of mean

The flanged lead was unipolar, 7 French Diameter at the pacing tip, with a taper increasing to a diameter of 10 French at the flange. Thirty-three leads of this type were implanted.

The tined lead was unipolar and had four tines made of silicone rubber, 2.5mm. long, placed about 3mm. from the pacing tip. The tines were angled at 45° from the body of the lead. The tip diameter was 8 French. Thirty-nine leads of this type were implanted.

Results

The cephalic vein was used successfully in 82% of both groups. The external jugular vein was used with 3% of the flanged leads and 8% of the tined leads, and the internal jugular vein was employed in 15% and 10% of cases respectively. Electrical parameters are summarized in Table 1. Differences between measurements with the two different leads were not statistically significant. No particular problem at placement was encountered with either type of lead. There was no perforation at placement, and no documented perforation postoperatively.

TABLE 2
Complications

	Flanged Lead	Tined Lead
Dislodgment	1	0
Perforation	0	0
Failure to Sense/Pace	2	1

Complications are summarized in Table 2. The only dislodgment was with a flanged lead which displaced into the out-flow tract the day after surgery. Three patients had repeat surgery because of failure to sense or pace without evidence of dislodgment on X-ray, two with the flanged lead and one with the tined lead. One patient was a 93-year-old female with sudden loss of capture and sensing three days after implantation of a flanged lead. This was corrected readily by repositioning the lead. Poor sensing was noted in a 70-year-old male nine days after placement of a flanged lead. At repeat surgery, only very low voltage R-waves were recorded with repeated repositioning of the lead. Therefore, a sutureless myocardial lead was placed in an area with excellent R-waves. Both patients did well after repeat surgery. One patient with a tined lead, an 81-year-old male, had repeat surgery because of failure to sense or drive one month postoperatively. Remanipulation of the lead resulted in satisfactory function. There was no diaphragmatic driving, no infection, and no erosion during the follow-up period.

There was one in-hospital death. It occurred on the 36th postoperative day from congestive heart failure in a 75-year-old male. A tined lead had been placed because of complete block three weeks after a myocardial infarction. The pacemaker functioned normally and he was not pacemaker dependent.

There were two additional deaths after discharge from the hospital following pacemaker inplantation during the follow-up period. Both were patients with sick sinus syndrome and the deaths were not pacemaker related. Both had the flanged lead. One died in respiratory distress 16 days after pacemaker implantation. The other patient died of acute myocardial infarction eight days after discharge and 17 days after pacemaker implantation.

Discussion

The etiology of early transvenous electrode failure, excluding fracture and insulation failure, can be divided into two broad categories. The more common is displacement of the lead from its intended position by dislodgment or perforation. The other category is failure to sense or drive or both, with no apparent displacement on X-ray. Some authors consider the second category to be the result of "micro-displacement" or perforation, but the consensus is that a lead can cease to function adequately without any displacement or perforation. Repeat surgery is necessary when dislodgment or perforation occur; the malfunctioning lead, without apparent displacement, also needs repositioning unless a multi-programmable generator has been implanted and the dysfunction can be corrected by appropriate reprogramming. Dislodgment, the most common of these problems, occurs in up to

26% of the series reported.[5] Surgeon inexperience is probably the chief reason for high failure rates in this category, and the electrode manufacturers have responded by attempting to provide a lead that will stay where it is placed anywhere in the right ventricle. Several reports have indicated that the leads with the short silicone rubber tines rarely dislodge, and we had no dislodgments in this series of 39 cases employing this type lead.[4]

However, failure to sense or drive without apparent displacement of the lead is a problem which will probably demand a different solution. Before introduction of the electrodes with either flanges or tines, we experienced early lead failure without displacement in twice as many cases as in those with obvious dislodgment. This complication has not been prevented by use of the tined lead. Dislodgment in this series was a minimal problem with an overall incidence of 1.4%. However, a total of 4% required repeat surgery because of lead failure without dislodgment. Therefore, this study suggests that although dislodgment can be prevented or minimized by employing a tined lead, the poorly defined problem of lead failure without displacement remains unsolved and continues to require repeat surgery in an unacceptably high percentage of patients.

We have not found any reason to reject the tined lead in this early experience. Although it is more difficult to place in small veins than the leads without tines, we succeeded in placing it in the cephalic vein in 82% of the cases, the same as with the flanged lead. The tined lead provided a lower pacing threshold (Table 1) although this was not statistically significant because of the small numbers. In the one patient in whom we had to reposition a tined lead one month postoperatively, there was no difficulty in removing the lead from its original position, although it gave the feeling of secure attachment.

Conclusions

There was no dislodgment in this series of 39 cases of placement of a permanent transvenous pacemaker lead with the dislodgment feature of 2.5mm. silicone rubber tines. However, failure to sense or pace without dislodgment remains an unsolved problem and it appears to be distinct from the issue of the stability of the position of the lead, occurring in 4% of this series.

The presence of tines on the lead had no adverse influence on access to the cephalic vein or on electrical parameters. Therefore, use of the tined lead is recommended, since it will reduce the incidence of dislodgment in the early postoperative period. ◀

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Acknowledgement

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Special Articles

University of Illinois College of Medicine Centennial

By Joseph H. Kiefer, M.D., and Elisabeth Wittman/Chicago

The city of Chicago was incorporated in 1833. Within ten years, the first medical school was founded. By the turn of the century there were 26 medical schools and 45 hospitals and sanitaria. Early in its history, Chicago was a center for medical education.

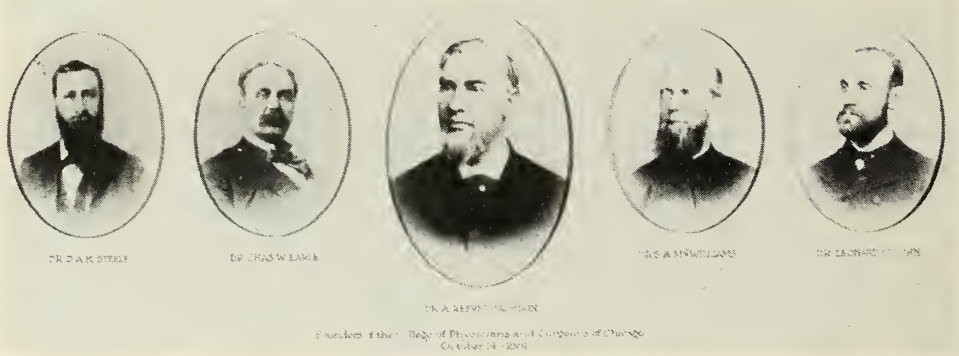


Figure 1
Five Founders, College of Physicians and Surgeons of Chicago. (Photo courtesy, UI Medical Center Archives.)

In October 1881, one hundred years ago, five men incorporated a new medical school, the College of Physicians and Surgeons of Chicago. In 1876, Charles Warrington Earle first sounded out several of his colleagues on the idea of a new school. As a result, he and Leonard St.John, Samuel McWilliams, Daniel A.K. Steele and Abraham Reeves Jackson pooled their financial resources to start the school. (Figure 1) Their first task was to erect a college building and it was built directly opposite Cook County Hospital at Harrison and Honore Streets. The cover photo shows the building that first housed the College of Physicians and Surgeons of Chicago. Erected by the founders in 1882, it was directly opposite the front entrance of Cook County Hospital. The section shown left center is the 1893 laboratory addition and the building farthest left was later the West Side Hospital.

The five founders enlisted other faculty, some of whom bought additional shares of stock in the project. The first students were enrolled in September 1882, when the first faculty numbered 28 and there were 100 students. Affiliation with the University of Illinois was arranged in 1897, but it was not until 1913 that it became an integral part of the University.

The academic year 1981-1982 has been designated the Centennial Year of the University of Illinois College of Medicine. One event in celebration will be publication of a history of the College by Patricia Spain Ward, who has been researching the history of the College for the last two years.

Joseph H. Kiefer, M.D., is a board certified urologist and professor emeritus at the University of Illinois Abraham Lincoln School of Medicine. A past president of the Chicago Medical Society North Shore Branch and Chicago Urological Society, as well as the Society of Medical History of Chicago, Dr. Kiefer has been very active in the medical history field. He formerly served as acting chairman at the UI Abraham Lincoln School of Medicine, Division of Urology and a professor of urology for the UI College of Medicine.

Elisabeth Wittman is an archivist and librarian in the Special Collections section of the Library of the Health Sciences, University of Illinois at the Medical Center. She holds a master's degree in library science from the University of Wisconsin-Madison Library School.



Figure 2
The second building of the college was the converted West Side High School. The 1882 building is in the background at left. Notice the sign for the West Side Free Dispensary, an out-patient clinic of the school. (Photo courtesy, UI Medical Center Archives.)

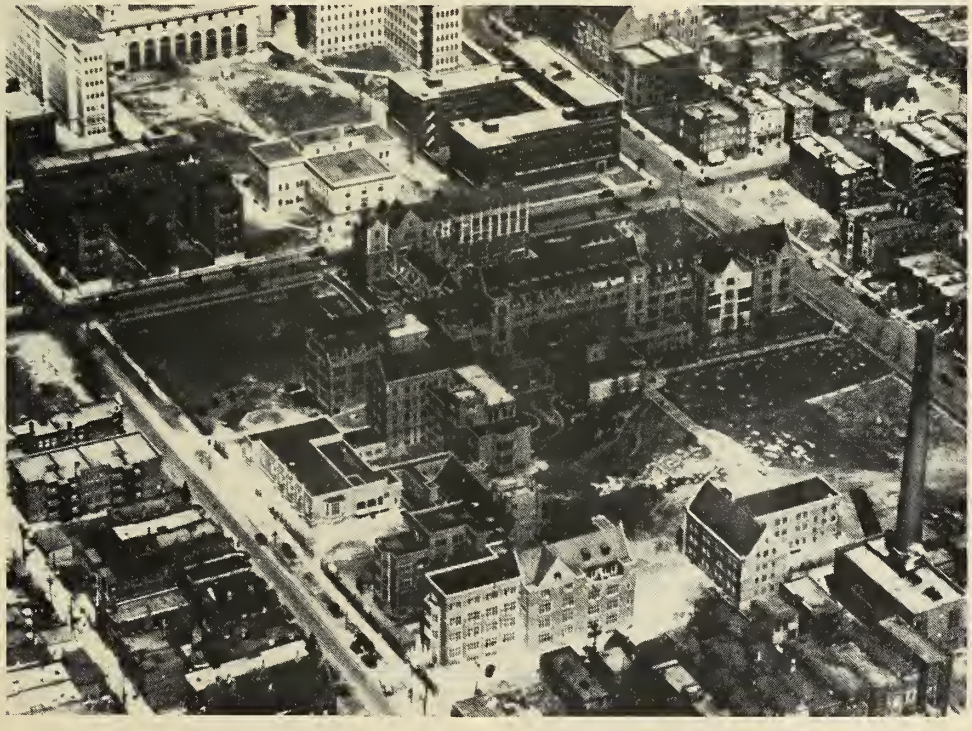


Figure 3
This aerial view of the campus shows the first sections of the present buildings (center) shortly after completion in the mid 1920s. Cook County Hospital buildings are across Polk Street, top left. University units shown are a section of classroom and laboratory building, the Quine Library and original unit of the Research and Educational Hospital. (Photo courtesy, UI Medical Center Archives.)

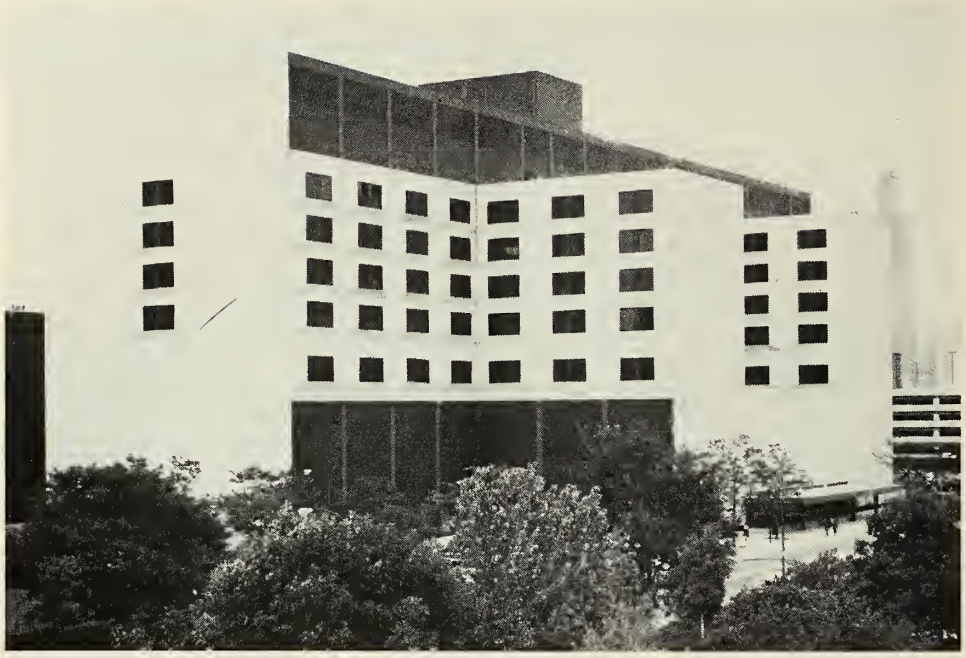


Figure 4
The most recent addition to medical facilities of the University of Illinois at the Medical Center is the University of Illinois Replacement Hospital, dedicated on October 17, 1980 and fully occupied by early in 1981. (Photo courtesy, UI Medical Center Office of Public Affairs.)

Early Affiliations

The story of how the College of Physicians and Surgeons became a part of the University of Illinois has been fully addressed by Ward in her historical research. The College has enjoyed great success in attracting students and in acceptance of its graduates by the medical profession. However, it was not always a financial success.

Several revisions in the corporate arrangements were necessary. The 1897 affiliation with the University of Illinois resulted, in part, from these considerations and, in part, from the fact that the University had no medical education facility. As a result, the College had a dual identity as a College of the University and as the College of Physicians and Surgeons until 1913.

That year, and those immediatly preceding it, witnessed much negotiation between the stockholders, the university and state government, and also, very importantly, the school's alumni. Concurrent changes in medical education made the existing financial arrangements unfeasible and new resources were required; full affiliation with the university became desirable and necessary. The state legislature failed to provide funds to purchase the college for the state and the college disaffiliated with the university for a time in 1912-1913. It was the alumni, along with faculty stockholders, who donated shares of the college which they had owned and purchased others and then presented them as a gift to the University in 1913.

As a result, the old College of Physicians and Surgeons went out of existence and the University of Illinois College of Medicine took its place. The College became the second unit of the University to be located in Chicago, joining the College of Pharmacy. The College of Dentistry was added at the same time, as it had been a department of the College of Medicine since 1901. The College of Dentistry was still housed in the original Physicians and Surgeons building. An adjacent building, formerly the West Side High School (Figure 2) had been occupied by the College of Medicine since 1901. This and the West Side Hospital, occupied in 1896, were the newest facilities available.

Architectural Growth

In 1919, a major step for the College came when the state authorized purchase of a full square block of vacant land south of Cook County Hospital for the purpose of erecting all new facilities. The land was the site of the West Side Ball Park, vacated earlier in the decade by the Cubs when

Wrigley Field was completed on the north side in 1926. The original unit of the Research and Educational Hospitals with the Quine Library was completed by 1925. (Figure 3) Since that time, building has been continuous; the newest unit is the new University of Illinois Replacement Hospital, which opened in 1980. (Figure 4)

The accompanying illustrations show some of the physical changes that the College and the University of Illinois at the Medical Center have undergone through the years. The earliest facilities were considered innovative at the time of their construction but as the college grew and affiliated with the university, the buildings became inadequate. The area surrounding the college was a heavily populated depressed area which in 1941 was marked off by legislative action as the "Medical Center District." A Commission was given eminent domain over the entire area, which allowed the University and other medical institutions to obtain needed space for new buildings.

Academic Expansion

Since 1969, the college has been reorganized and expanded. It includes two basic science schools, in Chicago and Urbana and clinical schools at Peoria and Rockford, in addition to the Abraham Lincoln School of Medicine in Chicago. The College also established hospital affiliations in all of these cities, including the Metro-Six group of hospitals in the city of Chicago.

In addition to Patricia Spain Ward's centennial history of the College of Medicine of the University of Illinois, there are plans for a full year of Centennial events. The first event is a scientific symposium, "Medicine in Transition," to be held October 1-2, 1981. The chair of this event is Edward Cohen, dean of the School of Basic Medical Sciences, Chicago. The keynote speakers are two Nobel Laureates, Rosalyn Yalow and John Bardeen. The published proceedings of the symposium, including a historical section by Ward, will be available for purchase at the time of the meeting. A second major event of the year will be, "Medicine and Mankind in Transition," June 3-4, 1982. This Symposium will be chaired by Max Samter, professor of medicine *Emeritus.*

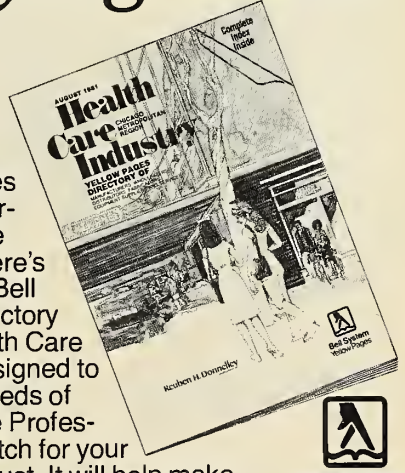
While these meetings are taking place in Chicago, other centennial events are scheduled throughout the state, Rockford, Peoria, Urbana, Decatur and the Quad Cities. Some additional Chicago events include an International Conference on Medical Education in the Spring of 1982, a Centennial Ball and the 13th Annual Midwest Regional Student Research Forum. The College's Class of 1982 has been designated the Centennial Class. Their June 11, 1982, Commencement will be another focus of celebration, with traditional alumni events, speakers and honorary degrees given.

All physicians in Illinois are invited to mark this centennial year along with the faculty, administrators and alumni of the college. The centennial symposia and Ward's history should be of particular interest to all.

This occasion affords us the opportunity to examine an important segment of the history of medical education in the state and the city of Chicago. Interwined with this, is much relating to the history of Cook County Hospital and the entire West Side Medical Center as well as the evolution of Chicago as one of the most important centers of medical education in the country.

For details concerning any and all of these events, call or write Una Creditor, Office of the Executive Dean, College of Medicine, University of Illinois at the Medical Center, Chicago, P.O. Box 6998, Chicago, Illinois 60680, Phone: (312) 996-3500. ◀

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A Spectrum of Radiographic Manifestations
Pulmonary Sarcoidosis

By Lisa K. Miller, M.D. And Leonid Calenoff, M.D./Chicago

Pulmonary sarcoidosis has a spectrum of radiographic manifestations which are easily recognized in some instances but create a differential diagnostic problem in others. This is particularly true in atypical or late presentations, when pulmonary sarcoidosis may simulate other lung diseases.

Sarcoidosis is a systemic disease of unknown etiology characterized pathologically by non-caseating granulomatous lesions. The lesions have a predilection for many organs, including the lung, liver, spleen, lymph nodes, skin and bone. Diagnostic proof of the disease is obtained by histological examination of biopsy material from lymph node, lung, liver or skin. A positive Kveim test is complementary diagnostic evidence.[1]

The hallmark of early sarcoidosis is bilateral hilar and right paratracheal lymphadenopathy (Stage 1). The disease may progress to parenchymal involvement with reticulonodular pattern, large nodules or alveolar infiltrates (Stage 2). The lymph nodes can regress while the parenchymal changes remain (Stage 3). With further progression, advanced pulmonary fibrosis, bulla and cavity formation are seen (Stage 4).[2]

Lymphadenopathy

Nodual enlargement can present alone or in association with parenchymal disease. Intrathoracic lymphadenopathy can be present in approximately 73% of patients with sarcoidosis.[3] The most frequent combinations are bilateral hilar, right paratracheal, and aorto-pulmonic lymphadenopathy (Figure 1). The aorto-pulmonic involvement has previously received much less attention than the bilateral hilar and right paratracheal involvement. Less common is involvement of sub-carinal, anterior and posterior mediastinal and para-aortic nodules.[4] Lymphadenopathy alone is highly suggestive of sarcoidosis, but biopsy confirmation is needed, as lymphoma or metastatic disease can also present in this manner.

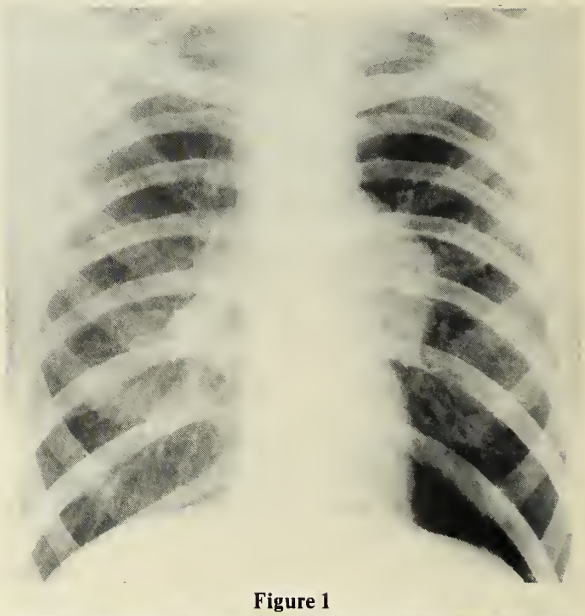


Figure 1
Bilateral hilar and right paratracheal lymph node enlargement in a 25 year-old man with sarcoidosis.

Reticulonodular Pattern

The most common parenchymal abnormality is a reticulonodular pattern, either diffuse or localized.[1] If coupled with lymphadenopathy, the diagnosis is readily suggested. Pure nodular, mixed reticulonodular, or pure reticular densities may be seen (Figure 2). The nodules range from 3-5mm. in diameter and a pure nodular pattern

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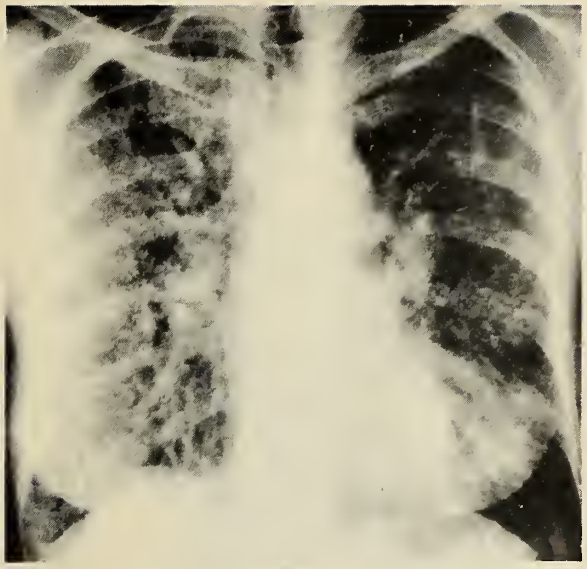


Figure 2
Sarcoidosis in a 50 year-old woman with diffuse reticulonodular pattern coupled with lymphadenopathy.

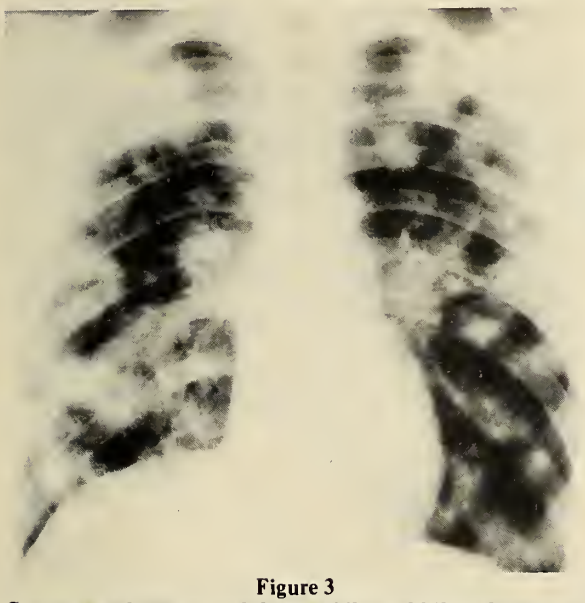


Figure 3
Scattered pulmonary nodules and bilateral hilar adenopathy in a 24 year-old man with sarcoidosis. The nodules have fuzzy, ill-defined margins.



Figure 4
Alveolar disease in a 24 year-old man with sarcoidosis, characterized by "bat-wing" distribution, acinar nodules, and coalescence.



Figure 5
Advanced sarcoidosis in a 41 year-old woman with fibrotic changes of unilateral predominance and left hilar retraction.

resembles miliary disease. The pure reticular pattern consists of fine linear densities with central lucencies appearing in a "honeycomb" pattern. The mixed reticulonodular pattern comprises both the miliary nodules and the fine linear densities.

Multiple Large Pulmonary Nodules

Large pulmonary nodules have been noted in up to 4% of patients with sarcoidosis.[2] These multiple nodules may be seen alone or in association with lymphadenopathy, fibrosis, infiltrates or miliary disease. The nodular margins tend to



Figure 6A

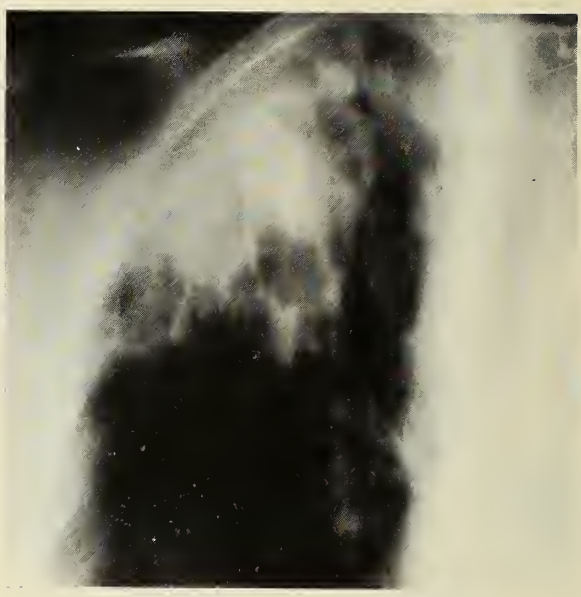


Figure 6B

A. Advanced pulmonary fibrosis with mainly upper lobe distribution and bronchiectatic changes in a 48 year-old woman with sarcoidosis. B. Tomogram of the right apex demonstrates thick-wall cavity with *Aspergillus* mycetoma formation.

be fuzzy and ill-defined (Figure 3). The nodules are often mistaken for metastatic disease. Lymphoma, septic emboli, infectious disease (tuberculous or fungal), immunologic disease (Wegener's granulomatosis, rheumatoid lung) and pneumoconiosis are also in the differential diagnosis.

Alveolar Infiltrates

The alveolar form of sarcoidosis can occur in as many as 20% of cases.[1] The alveolar pattern is characterized by segmental or lobar distribution, fluffy margins, air bronchograms, coalescence and acinar nodules (Figure 4). Transition between the miliary, large nodular, and alveolar form has been found to occur readily.[5] These alveolar infiltrates can be confused with pneumonia, alveolar cell carcinoma, alveolar proteinosis, or pulmonary hemorrhage.

Fibrosis

On occasion, a patient's initial radiographic examination will show a late stage of sarcoidosis with advanced pulmonary fibrosis and possibly bulla formation and bronchiectatic changes. These findings can be seen in approximately 25% of sarcoidosis patients.[6] This advanced stage of sarcoidosis can easily be confused with tuberculosis or other inflammatory diseases, depending upon the distribution. Fibrosis is the result of granulomas which do not resolve. The end-stage linear fibrotic changes are coarse with strands of varying thickness. Contraction secondary to fibrosis with hilar retraction may occur (Figure 5). Conglomerate masses, pneumothorax and pleural effusion can occur. Between the fibrotic strands and distorted vasculature, areas of emphysematous bulla can be seen. When the fibrosis is bilateral and prominent in the upper lung fields, as is often the case, differentiation from tuberculosis is very difficult. Cystic bronchiectic changes may be present.

Cavitary Lesions

Cavities are a complication of fibrocystic sarcoidosis which can be seen in 12.5% of patients with parenchymal involvement.[6] Cavitary lesions can also occur in other fibrocystic lung disease, such as tuberculosis, bronchiectasis, pneumoconiosis or histoplasmosis. These cavities are abnormal air spaces with thick walls and are surrounded by masses of hyaline fibrosis. A mycetoma can be found in 40% of patients with cavitary lesions (Figure 6). Decubitus views can show mobility of the mycetoma, almost invariably caused by *Aspergillus.*

In the spectrum of pulmonary manifestations of sarcoidosis, the "classical" radiographic pres-

entation of lymphadenopathy with or without reticulonodular parenchymal changes is usually well appreciated. However, the less typical manifestations of sarcoidosis, ranging from large nodular and alveolar patterns to fibrocystic disease and cavitary lesions, are often a diagnostic difficulty. Therefore, sarcoidosis must be included in the differential diagnosis of a significant number of abnormalities seen on the chest radiograph. ◀

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Case Reports

Cutaneous Larva Migrans

NASIRUDDIN KHOKHAR, M.D./HAVANA

Cutaneous Larva Migrans is a migratory intensely pruritic skin eruption caused by percutaneous invasion and subsequent migration of nematode larvae. It is also known as creeping eruption.

Cutaneous Larva Migrans has been reported mainly from the Southeastern United States particularly Florida, Georgia, South Carolina, North Carolina and Alabama, although it is found in all the southern states from Texas to New Jersey.[1] A case of this infection is described in Illinois. This explains the transport of a helminthic disease by infected animals from endemic area to remote places where this infection is not commonly seen.

The patient, a 58-year-old white male in otherwise good health, presented with skin lesions on both legs accompanied with severe itching of one week's duration. He denied any previous skin condition or any symptoms related to the respiratory tract or any recent travel. He worked as a foreman in a local factory. He had recently spent several days working on his lawn and garden. Further questioning revealed that patient's neighbors had some visitors from Texas who had a dog along with them and that this dog had soiled patient's lawn for the past several days.

Physical examination showed papulo-pustular lesions on both legs below the knees with some oozing. There were characteristic erythematous, tortuous and linear skin eruptions all over the legs and both feet; buttocks, thighs, hands and other parts of body were free of rash. Systemic examination was negative.

Patient was prescribed Thiabendazole 25mg/kg/day for two days along with Chlorpheneramine Maleate for relief of itching. Follow-up exam after four days showed marked improvement of lesions but some were still present. Another treatment with oral Thiabendazole was given and a subsequent examination revealed complete resolution of skin lesions with relief of pruritis. Six months later, there were no further skin or systemic symptoms.

Discussion

Cutaneous Larva Migrans is caused by infective larvae forms of the hookworm species which produce intestinal infection in dogs and cats. The most common cause is Ancylostoma braziliense. Occasionally *A. caninum* is responsible. Human hookworm like *Nector americanus* and *A. duodenale* may also produce a similar rash of shorter duration. *Strongyloides stercoralis* causes perianal eruptions called Larva Currens. Causes of Cutaneous larva migrans are described in Table 1.

Infected cats and dogs deposit fecal material containing ova *A. braziliense* on the soil. In optimal temperature, the eggs hatch. The larvae develop into the infectious third stage forms in three to four days. Sandy, moist, warm and shady areas are favorable for the parasite. Larvae directly invade the skin and penetrate with the help of a collagenase-like enzyme.[2] The disease is seen in plumbers, pipefitters, gardeners, farm workers, swimmers on beaches and anyone who must work under buildings and crawlways where skin comes in contact with soil.

Initial eruption occurs on hands, feet, legs and buttocks: the areas which have come in contact with the ground. Erythematous papular pruritic rash develops in a few hours. Migration of larvae causes serpiginous tunnels within a few days. Larvae advance at a rate of one to two cm/day. The eruption then becomes vesicular and secondary infection with scabbing and scarring may occur. Larvae may stop migrating within a few days or weeks or may continue for as long as a year if untreated, with periods of quiescence alternating with migrations. Larvae ordinarily remain in skin epidermis but in rare instances may be found in sputum along with pulmonary infiltration

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TABLE 1
CAUSES OF CUTANEOUS LARVA MIGRANS[5]

PARASITE	FREQUENCY	DATE DESCRIBED
Non Human Hookworm		
Ancylostoma braziliense	Common	1910
A. caninum	Uncommon	1859
Uncinaria stenocephala	Rare	1884
Bunostomum phlebotomum	Rare	1900
Human Parasites		
A. duodenale	Uncommon	1933
Necator americanus	Uncommon	1933
Strongyloides stercoralis (Larva Currens)	Rare	1926

and eosinophilia.[2]

Diagnosis is by characteristic clinical appearance of eruption. Biopsy of skin may reveal infecting larvae. Stool exam is not helpful.

The treatment is directed towards killing the larvae. Thiabendazole is drug of choice which can be given orally as 25-50 mg/kg/day for 2 days[3] in severe cases or locally as 15% lotion or cream[4] QID for 10 days in mild cases. Oral dose may be repeated in few days, if necessary. Side effects of oral Thiabendazole are nausea, vomiting, dizziness, drowsiness and hematuria.[2,3] Ethyl Chloride spray has also been used to kill larvae in mild cases. Non specific treatment includes aluminum acetate soaks, topical anesthetics or oral antihistamines for pruritis and antibiotics for secondary infection, if present.

Prevention of infection requires better animal control and periodic deworming of all dogs and cats. Protective clothing by workers in high risk areas is also helpful.

This case emphasizes the need for physicians in non endemic areas to be aware of such parasitic infections. ◀

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Case Reports

Report of Two Cases

Intrathoracic Paraganglioma Arising From Aorticosympathetic Paraganglion

By Foroogh K. Jazy, M.D., Wagih M. Shehata, M.D., F.F.R., Rafael Ramirez, M.D., James M. Hall, M.D., Sister Joseph Ignatius, M.D./Cincinnati

Two cases of aorticosympathetic paragangliomas arising in the posterior costovertebral sulcus are described. The presenting symptoms, workup, treatment and review of the literature are discussed.

The carotid body was first described by VonHaller in 1843. It was not until 1891 that the first case of tumor of this body was reported by Moorhan. In 1950, Lattes reported two patients with paragangliomas originating in the area of the aortic arch. Since that time an additional 51 cases of intrathoracic paraganglioma have been reported. Eleven of these were located in the costovertebral sulcus (mediastinal aorticosympathetic paraganglioma). [1-4.7-10.14.15.] We elected to report our two cases because it is a rare tumor.

Case 1

A 36-year-old black male presented complaining of dull pain in the right lateral chest. The chest X-ray and subsequent tomogram showed an extra-pleural posterior mediastinal mass in the right paraspinal region. The patient denied dyspnea, dysphagia or cough. He had a ten pound weight loss.

The physical examination was unremarkable. Hemoglobin was 14.4, WBC 10,400 and barium swallow showed esophageal diverticulum. The nephrotogram and infusion pyelogram were normal. A right thoracotomy was performed. He was found to have a lobular, quite vascular mass in the right costovertebral sulcus extending from D7-D9 (4x8cms.) interspaces. Partial resection was done. The patient lost 1,500cc of blood during surgery. Postoperatively, he received 4,000 rads externally by anterior/posterior port and an additional 1,600 rads boost by reduced field to the tumor bed (total of 5,600 rads in 46 days). Two months after completion of treatment, he was lost to followup.

Case 2

A 24-year-old white female was admitted to our institution with a year's history of pain in the upper thoracic spine. Three weeks prior to admission she noticed numbness and weakness of the lower part of her body from the nipple area down. The chest roentgenogram and tomogram of the dorsal spine (Figure 1) revealed the presence of a 9cm. rounded mass in the left posterior mediastinum overlying the third rib and collapse of the third dorsal vertebra.

Myelography revealed a complete extradural block at D3 interspace. An emergency decompressive laminectomy was performed with complete return of her motor function. A tumor was found surrounding and extending into the body of the third dorsal vertebra. It also extended into the epidural space and laterally on the posterior portion of the third and fourth ribs. The rib portion of the

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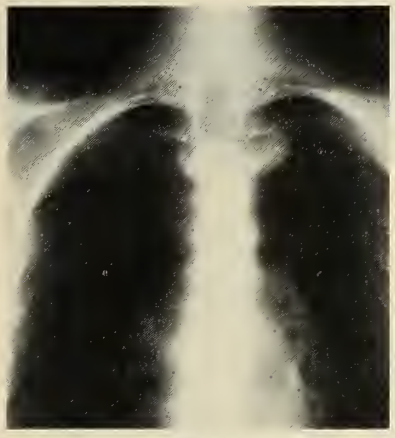


Figure 1
Case 2: Laminogram of the mediastinum shows compression of D3 vertebral body and bilateral soft tissue mass at this level.

tumor was well encapsulated and completely removed. The extradural portion of the tumor was partially resected. Postoperatively, she received 4,200 rads by two posterior wedge oblique ports utilizing 21 treatments in 49 days. The patient was free of disease until 18 months later, when weakness of the left upper extremity developed. Repeat myelogram revealed an extra dural block at C7 with diffuse infiltration of the tumor up to the C5-C6 epidural space. She received 4,000 rads in four weeks in the C7 to C3 epidural space.

Six months after conclusion of therapy, the patient developed progressive weakness of her lower extremities. Myelogram revealed an extra-dural mass at D10, D11 and twelfth dorsal spine. She underwent laminectomy with partial excision of epidural paraganglioma with no recovery in her paraplegia. Her chest Xray also showed lung nodules. At this writing, patient was in the hospital with progressive lung metastases and recurrent mediastinal mass.

Discussion

The morphologic appearance of the two cases (Figures 2 and 3) was identical to that classically described for the aortico-sympathetic paraganglioma. This was mainly a small mass of round uniform cells supported by a highly vascular fibrous tissue stroma, with mild pleomorphism and numerous argyrophilic granules within the tumor cells (by Bodian and Fontana stains).

Intrathoracic paragangliomas are very rare tumors. Despite its rarity, problems encountered in the diagnosis and proper treatment ensure continued interest in such tumors.

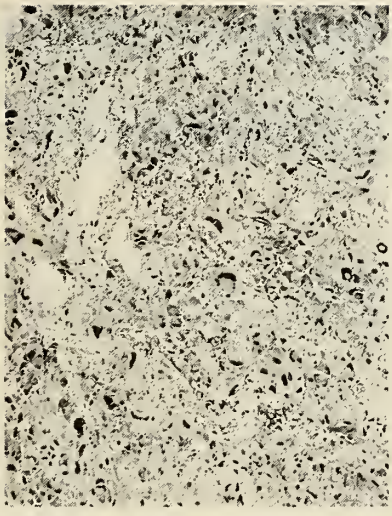


Figure 2
Case 1: Tumor shows marked cellular and nuclear pleomorphism. Hyalinized blood vessels are present.



Figure 3
Case 2: Relatively uniform polyhedral cells arranged in cell nests surrounded by delicate vascular fibrous tissue. Collagenous fibrous tissue septa are also noted. (Reticulin stain)

The extra-adrenal paraganglion system comprises minute macroscopic bodies and microscopic cell groups associated with the autonomic nervous system. These are distributed symmetrically and segmentally in the para-axial regions of the trunk and in the vicinity of the ontogenetic gill-arches.

Glenner and Grimley[6] divided the extra-adrenal paragangliomas into four groups on the bases of location, innervation and histology: branchiometric, aorticosympathetic, visceral autonomic and intravagal. The aorticosympathetic paraganglioma are associated with segmental ganglia of the sympathetic chain, and as such are found along the costovertebral sulcus in both the thorax and retroperitoneum. Both of our patients' tumors were arising in the para-vertebral area without a clear relationship to the aorta.

Eight out of 11 patients reported in the literature with aortico-sympathetic paraganglioma were alive and free of disease up to 2 to 15 years followup (seven out of eight had complete excision). Two of the remaining three patients were alive with documented residual disease (post surgery): one of them for four and a half years. The remaining one died during surgery. One of these eight patients developed second paraganglioma. None of the eleven patients developed distant metastases.

Complete excision is the treatment of choice with relatively good survival[5,13] in patients with paragangliomas. Although radiation therapy has proven ineffective as the primary treatment of the paraganglioma, there has been a significant reduction in tumor vascularity following irradiation therapy,[11] and it is a useful adjuvant therapy in paragangliomas, particularly for those tumors which can not be completely excised.[12] ◀

References

A complete list of references for "Intrathoracic Paraganglioma Arising from Aorticosympathetic Paraganglion," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

Special Articles

Inexpensive Data Retrieval in the Office

By John F. Monroe, M.D. And R. M. Gulley, M.D./Peoria

The authors describe a system for retrieval of data in an ambulatory internal medicine educational unit. The system is based on the use of patient cards, birth month filing, problem oriented medical record, an adaptation of "Pri-Care Code" and a manual McBee Keysort card system. The system is easy to install, inexpensive and adaptable to primary care practices. It provides a ready means for implementing preventive care practices, determining practice size and demographic characteristics, auditing physician behavior, facilitating research, and administering an educational program for primary care residents.

The most frequent patient-physician interaction occurs in the physician's office. Until recently, this was one of the least critically examined and most neglected study areas of clinical medicine. The increasing interest in understanding health care delivery, expanding health maintenance techniques, establishment of cost-effective strategies, outpatient training of primary care residents and measuring of CME value all emphasize the importance of this area and the need for individual practice data.

Our interest in developing an office record system with inexpensive data retrieval capabilities was primarily prompted by educational requirements. We identified a need to develop a system to help us evaluate each resident's range of experience and ability, and to demonstrate a system to the residents which could be utilized in their future private practices.

Design objectives for the office data retrieval system were stated as follows: (1) The system must be inexpensive; (2) It must operate with usual office personnel; (3) It must require minimum physician time; (4) It must be compatible with most established office systems; (5) Its complexity must increase in a step-wise fashion without alteration of early steps and (6) It must be easy to convert to computer use when economically feasible.

Office Characteristics

Patients: Our practice included approximately 1000 active patients ages 12 to 94. The patients constitute a wide spectrum of socio-economic status.

Physicians: Two attending internists and ten second and third year internal medicine residents practice in this "model office." Each resident has a panel of patients assigned to his care for the three years of his residency. The resident functions as the patients' private physician, as do the attendings, and see other physician's patients only when they are covering for vacation or meeting times. In effect, the office is designed to function as a large "group practice".

Staff: There are four full time employees: a medical secretary-receptionist, a medical transcriptionist, an RN, and a clinical assistant.



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JOHN F. MONROE, M.D., is an internist and pharmacolgist who serves as medical director for the Peoria Poison Center. A staff physician at St. Francis Hospital-Medical Center, Peoria, Dr. Monroe has held several clinical and administrative positions in private industry.

Records: The chart for each patient is an 8½ x 11″ folder containing all of the patient identification and the complete medical record. Each chart has a problem list derived from the Weed Problem Oriented Medical Record System.[1] The charts were filed alphabetically.

System Implementation

Filing System Revision: A Rolodex® card was typed for each patient. It contained the patient's name, address, phone number, and physician. These cards were filed alphabetically.

The charts were refiled by grouping them into 12 sets determined by the patient's birth month. Each set therefore designated a month and was so numbered (*i.e.,* January #1, October #10).

The charts within each birth month set were randomly assigned consecutive numbers, 1 to infinity; each individual chart had a unique number, such as 1-12 (twelfth chart of January) or 10-33 (thirty-third chart of October). This number was entered on the patient's Rolodex card and chart.

Each month was given a unique color coding by means of colored tape placed on the chart where it was visible when the chart was filed.

Chart: The entries on each problem list were coded with a Pri-Care number.[2] This code consists of a Roman numeral topic heading and an Arabic numeral designating a specific diagnosis. The code is a modification of the International Classification of Diseases-Amended Code.

McBee Keysort Card: Specific locations on a double row 8 x 5″ McBee Keysort® card were assigned to all data desired for recall evaluation. This included patient identification, age, sex, race, physician, and all Pri-Care numbers.

The punching of the Keysort card was simplified by tracing a Keysort card outline on a full sheet of paper with the specific definition of each hole printed on the margins of the paper. This is then put in a glassine cover to form a template (Figure 1).

Coding the card for punching consists of placing the unpunched card on the template and by direct reading of labels marking the holes to be punched with a colored wax pencil.

Correct punching of the card then was done by punching out the marked areas.

Maintenance of a System

Adding New Patients: As a new patient enters the practice, the chart number assigned is the number of the birth month of the patient plus the next open sequential number in that month. The Rolodex card, problem list, Pri-Care code and McBee card are complete as described above.

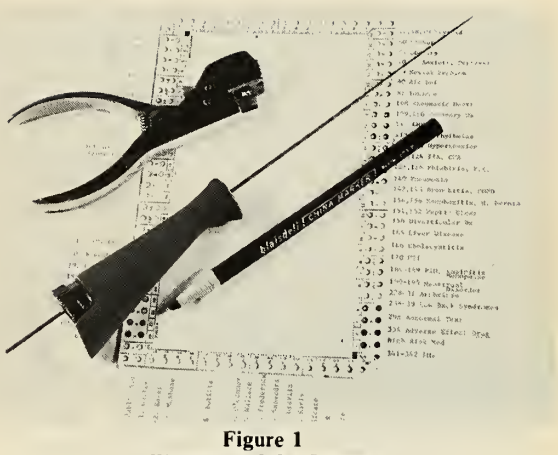


Figure 1
Elements of the System

Updating Established Patients: With the addition of new problems or higher resolution of old problems, the problem list is changed by the physician. The staff then Pri-Care codes the new entry and enters the data on the Keysort card.

System Cost

Material costs were approximately $135.00 total.

Time Costs: The typing of the Rolodex cards took approximately 25 hours and was done in spare moments by the secretary over one month's time. The refiling and color coding by birth month and entering the number on the chart and Rolodex cards was done by the four office staff members in a three hour period after office hours. Entering of the Pri-Care code on each problem list was done in spare time by office staff over a two month period. Approximately 25 staff hours were required.

Patient identification, problem list, Pri-Care number, chart number and physician entries on the Keysort card and the punching of that card were done by the same staff and took approximately 25 hours. Physician time was limited to explanation and demonstration only; no direct involvement was required. The supervision of the institution of this system was performed by one of the authors who had had no previous experience with the system. Figure 2 demonstrates the use of the cards. The "desired cards" fall in response to insertion of the probe.

Results

We feel this system has met our design objectives. As the figures show, the system is inex-

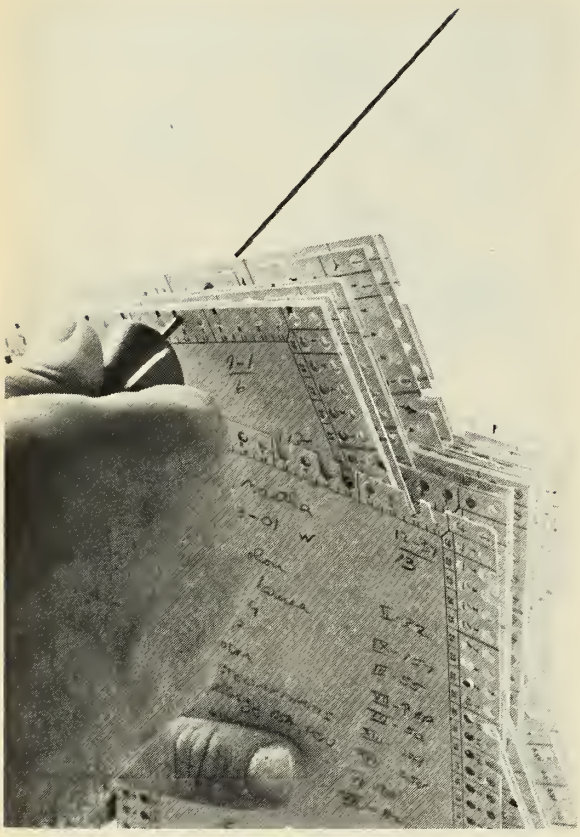


Figure 2
Sorting the Cards

pensive and was implemented by regular office staff with minimal physician explanation and time investment. The Keysort Coding System is a binary code and can be easily adapted to computer techniques without the need to handle the patient's chart. As the major component of the system is the patient's chart, which is present in all office systems, it is readily adaptable to most offices. In the eighteen months that we have used the system, we have realized a number of benefits.

Office Procedure Benefits

Reduction of filing errors: The switch from an alphabetical filing system to a numerical one and addition of color coding has markedly reduced frequency and severity of filing errors.

Screening facilitation: Shortly after completing the system we were able to begin a health screening program. Each patient's chart is now reviewed two months prior to his birthday month. Utilizing a screening form placed on the chart, his health screening needs are identified and he is mailed a card advising him to call the office for an appointment to complete his health screening maintenance needs. For example, in early August, the October charts are reviewed, contact initiated and appointments scheduled, allowing for estimation of the October work load.

Practice data: Since implementation of the system, we have ready access to data regarding the practice not previously available. This includes a continual update of the size of the practice and the demographic characteristics including male-female ratio, age, percentage on public aid, etc.

Recall capabilities: The system allows us, with ready and easy access, to recall those patients with specific problems when new therapeutic modalities become available or other information becomes known. For example, with the availability of pneumococcal vaccine, this system allowed us to pull the charts on all of those patients who possessed coded problems identifying them as a member of a high risk group and in need of the vaccination.

Benefits for Education

Resident education: The system allows the director of the office immediate access to each individual resident's patient panel, giving control over the size of that panel and the characteristics of the problems each resident is responsible for following. In addition, when a resident completes his three-year tour in the office, his patient panel can be redistributed among new residents coming into the practice in an ordered manner, allowing for maximum utilization of the clinical material.

Audit capabilities: We have instituted several audits on specific topics since application of this system. For example, we defined criteria and then reviewed our performance in treatment of hypertension. Even in the context of an educational office, several glaring deficiencies were noted in our approach to the treatment of hypertension in individual patients.

Board recertification requirements: One of the authors recently became due for recertification in family practice. The American Board of Family Practice requires review of specific charts from the physician's office practice. These charts are requested from a disease-oriented standpoint, *i.e.*, the physician is asked to produce a certain number of patients with chronic obstructive pulmonary disease, diabetes, obesity, etc. This system allowed that activity to take place in 15 minutes' time, and saved several hours' searching to identify proper charts under previous circumstances.

Benefits for Research

Application of the system in our office has

allowed us to institute several clinical research projects. We have begun a controlled study evaluating the utility of behavior modification as an approach to treating obese hypertensives. This system allowed us to pull all of those patients who had obesity and hypertension within 10 minutes. The cards could be assigned in a random fashion, utilizing a table of random numbers, into a control and experimental group within 30 minutes.

Discussion

Several illustrative areas are:

Office Management—When additions to office personnel or laboratory equipment are considered, many office systems do not readily provide the data base for an adequate cost-effective decision. With this system, if glucose analyzer is considered, cards of diabetics are sorted, charts pulled, and number and types of diabetes are recorded. The total number of glucoses done on these patients are counted and a data base is developed. The same type procedure can be used for any specific disease(s) that require specific laboratory tests or special office handling, such as identifying the need for a nurse practitioner to work with hypertensives.

Physician Performance—"How well do I care for Hypertensives?" is an easily answered question. The staff sorts the Keysort® cards and pulls the identified charts. Blood pressures obtained in this group during the past year are then recorded. Laboratory tests and physical examinations of target organs are checked as done or not done. In a short time, the physician can examine a record of his performance.

CME Needs—With many states now requiring CME credits for licensure (as well as board certification requirements for CME) this area has become more important. The number of CME courses has also increased dramatically, and the physician is confronted with the problem of how to choose. By using practice self-audit, areas for education are rapidly identified. These may be common conditions that present problems, or conversely, conditions rarely seen in a particular practice which require a refresher course.

Research

The need for collected research reports from well-run private ambulatory care offices is self-evident. Studies from the usual university outpatient clinics may not reflect the degree of control, patient compliance, and natural history of disease experienced in private practice.

As Smith[3] pointed out in a recent overview, the published data on the effect of treatment of mild hypertensives is based on less than 400 people and a period of observation is less than eight years. Compare this with the wealth of data already on file in the offices of ambulatory care physicians.

Finnerty,[4] in a companion article to Smith's, commented on the reasons for lack of compliance in hypertensives in one clinic. These points included: (1) Long wait for physician, average 2.5 hours; (2) Long wait for medicines, average 1.8 hours, (3) Poor follow-up; (4) A poor or nonexistent doctor-patient relationship and (5) Side effects of antihypertensive agents.

Certainly the first four listed are not usual findings in private practice and the fifth, while real, may also be related to the first four. An inexpensive data retrieval system such as this would readily permit integration of several differing practices.

Practice Benefits—When yearly examinations are used for health maintenance it is simple for the staff to review charts and contact patients for their appointments. The charts are filed by month so the review may be done without individual chart finding.

The most difficult measure of patient compliance is to find the individual who did not make the appropriate appointment. The filing by months in which routine examinations should be scheduled allows identification of those who did not respond to their notification.

Conclusion

We have described an office information retrieval system that can be implemented in a stepwise fashion. This system works well for us in answering questions concerning our practice. It is only a tool and ultimate benefits are determined by user needs.

With the increase in practice complexity and declining cost of computers, electronic data processing will eventually be available for most offices. Until then, this system provides a low cost method that fulfills most needs. The possibilities and applications of this system are limited only by the questions asked by the user. ◀

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2. "The International Classification of Health Problems in Primary Care (Pricare)," *Continuing Education for the Family Physician*, p.34, May, 1975.
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Medical Student Section in Action

Part Two

A Medical Education: Only For The Rich?

Last month's column reported on the high cost of U.S. medical education and described various student loan programs. Many of these programs have since been eliminated or curtailed. However, the high-interest Health Education Assistance Loan (HEAL) program is in full operation and will be expanded.

HEAL programs and their counterparts result in excessively large loan debts when medical training is completed. For example, borrowing $10,000 for each of four years at 15% interest (4% below the current rate) would mean a debt of $192,000 accrued for payment in a ten year period after residency. Extending the payback period to 15 years, the amount repaid jumps to $252,000. Certainly, students' debts will rise under such programs, perhaps with a concomitant rise in default rates.

Medical school financial aid officers must take the first steps in easing this dilemma. Students must be explicitly informed of the ramifications of accruing a debt. Although repayment provisions are noted, monthly payments, taxes, insurance and cost of living expenses are not corelated with the anticipated income. Debts of $100,000 and more are common. Students will certainly be unable to deal with such debts if adequate instruction is not given.

The debts, however, must be kept at a reasonable level or no amount of "debt-management instruction" will help. Since the federal government is bowing out of the financial aid market, state and local governments, medical schools and organized medicine must assume part of the burden. New loan programs supported at all levels must be developed.

It is hoped that ISMS will support establishment of state and local government loan programs for medical students. Illinois already spends millions of dollars in support of its state medical schools and tuition has remained affordable. However, as costs of living rise and students' incomes remain at zero, new loans to offset these increases become necessary.

Sharing the responsibility of financing medical education, ISMS has recognized its charge and hopes to fund 100 Illinois medical students in 1985. County societies need to get on this bandwagon as well. Most important, a tenable mechanism for such programs is needed. ISMS' commendable role in assisting medical students in financing their educations will soon become an important source of funds.

In addition to ISMS, individual physicians need to become aware of the sudden paucity of funds and increasing cost of medical education. Individuals might consider helping a medical student through school. Such a practice already occurs in Illinois on a small scale; the impact on the lives of those students supported is certainly significant.

Finally, loans and grants by private industries within Illinois presently provide a limited but meaningful source of monies. ISMS should consider soliciting businesses statewide to support medical education.

In short, there is an urgent need for attention to financial aid for medical students. Medical student sponsored bakesales and carwashes are not the solution. It is time for all those involved in medicine and medical education to devise a workable blueprint for the education of our physicians. ◀

Michael L. Nieder
Chairman, ISMS-MSS

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OBITUARIES

*Clemens, Raymond R., Joliet, died June 28, 1981 at the age of 51. Dr. Clemens was a 1960 graduate of the University of Michigan Medical School.

*Delfosse, John F., Chicago, died June 27, 1981 at the age of 62. Dr. Delfosse was a 1942 graduate of the Loyola University Stritch School of Medicine.

*Holmes, George W., Chicago, died June 11, 1981 at the age of 71. Dr. Holmes was a 1937 graduate of Rush Medical College.

**Johnson, Arthur Green, Arizona, died April 7, 1981 at the age of 97. Dr. Johnson was 1910 graduate of the University of Illinois School of Medicine.

**Levinson, Yale N., Florida, died January 4, 1981 at the age of 90. Dr. Levinson was a 1917 graduate of the University of Illinois School of Medicine.

**Sehring, George H., Joliet, died June 17, 1981 at the age of 78. Dr. Sehring was a 1929 graduate of the University of Michigan Medical School.

**Spafford, Howard Everett, DeKalb, died May 6, 1981 at the age of 77. Dr. Spafford is a 1930 graduate of the University of Michigan Medical School. ◀

* Indicates ISMS member
**Indicates ISMS member of the fifty year club

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"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

September 7	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
September 8	St. Francis Hosp. & A.C.S.	Blue Island
October 5	Hinsdale Sanitarium & Hosp. & A.C.S.	Hinsdale
October 5	Lake Forest Hospital & A.C.S.	Lake Forest
October 5	Grant Hospital & Chicago Lung Assn.	Chicago
October 12	Christ Hospital & A.C.S.	Oak Lawn
October 19	Sherman Hospital & A.C.S.	Elgin
October 20	Decatur Memorial Hospital & A.C.S.	Decatur
October 20	Lutheran General Hosp. & A.C.S.	Park Ridge
October 25	Victory Memorial Hospital	Waukegan
October 26	St. Francis Hospital & A.C.S.	Evanston
November 3	St. Francis Hospital	Blue Island
November 9	Rockford YWCA & Northern Illinois Interagency Council on Smoking	Rockford
November 16	St. Therese Area Trauma Satellite	Lake Villa
December 7	Christ Hospital & A.C.S.	Oak Lawn

Quarterly Reports: July 1-December 30, 1980

Formal Decision Regarding Discipline Of Medical Professionals Ordered by the State of Illinois Department of Registration and Education

This report includes formal decisions regarding issuance, refusal to issue, restoration, renewal or refusal to renew, revocation and suspension of licenses and probationary or other disciplinary action taken by the Department. It does not include formal decisions involved in the Director's approval of board or committee recommendations to issue licenses to persons passing licensure examinations.

MEDICAL PROFESSION

FORMAL DECISIONS REGARDING DISCIPLINE
ORDERED BY THE DEPARTMENT OF REGISTRATION AND EDUCATION

Name & Address Profession	Act (Ill. Rev. Stat.) & Section And/Or Rule Violated	Discipline Ordered Case Number	Date Ordered
Jerome J. Lubin 715 South Bradley Santa Maria, Cal. MEDICAL DOCTOR 36-23076	Chpt.111, Sec. 4433 (11) Respondent's license as a physician in the State of California was revoked.	Revocation 78-113	7-8-80
William F. McNabola 30 North Michigan Room 722 Chicago, Illinois 60602 MEDICAL DOCTOR 36-031579	Chpt. 111, Sec. 4433 (19) Respondent admits that circumstances surrounding his prescribing practice indicate that some prescriptions may have been written for non-therapeutic purposes.	5 Year Probation of Medical License; Revocation and Voluntary surrender of Controlled Substances License Consent Order 80-64	7-8-80
George Housakos 4921 N. Western Avenue Chicago, Illinois MEDICAL DOCTOR 36-26449	Chpt. 111. Sec. 4433 (19) Respondent wrote improper prescriptions for controlled substances.	6 Month Suspension of Controlled Substances License followed by Probation Consent Order 80-76	7-8-80
Standiford Helm 636 Church Street Evanston, IL 60624 MEDICAL DOCTOR CONTROLLED SUBSTANCES 36-21868 003-36-21868-1	Chpt. 111, Sec. 4433 (19) Respondent admits that some prescriptions may have been written for non-therapeutic purposes.	Revocation of Controlled Substances License Consent Order 80-88	7-31-80
Pascual Culala 5758 North Leroy Lincolnwood, Illinois MEDICAL DOCTOR 036-44849	Chpt. 111, Sec. 4433 (19) & Engaged in dishonorable, unethical or unprofessional conduct; wrote prescriptions for controlled substances for other than therapeutic purposes; making and filing false records and reports.	Revocation 78-140	7-31-80

Name & Address Profession	Act (Ill. Rev. Stat.) & Section And/Or Rule Violated	Discipline Ordered Case Number	Date Ordered
Jerome J. Wisneski 26 Sheldon, Rm 502 Grand Rapids, Michigan MEDICAL DOCTOR 36-040632	Chpt. 111, Sec. 4430 (4) (11) (19) Respondent's license was suspended in Michigan for 1 year.	Controlled Substances license Suspended until 7-15-81 Consent Order 80-61	11-21-80
Sinisa Princevac 5011 N. Lincoln Chicago, Illinois MEDICAL DOCTOR 36-49181	Chpt. 111, Sec. 4441 Respondent engaged in dishonorable, unethical and unprofessional conduct, of a character likely to harm the public.	Immediate Suspension 80-143	11-12-80
Leonard Pomper 2036 West Madison 10 South Paulina Chicago, Illinois 60612 MEDICAL DOCTOR 36-34732	Chpt. 111, Sec. 4441 Respondent engaged in dishonorable, unethical and unprofessional conduct of a character likely to harm the public.	Immediate Suspension 80-142	11-21-80
Basil Sklan c/o Chester Mental Health Center P.O. Box 31 Chester, IL 62233 MEDICAL DOCTOR 36-35201	Chpt. 111, Sec. 4433 Unprofessional conduct.	2 month Suspension 22 month Probation starting 12-19-78 2 month Suspension considered served 79-45	12-3-80

Other Formal Decisions Ordered By the Department of Registration and Education

Name & Address Profession	Act (Ill Rev. Stat.) & Section And/Or Rule Violated	Discipline Ordered Case Number	Date Ordered
Emanuel Stolman P.O. Box 1574 Upland, California MEDICAL DOCTOR 36-31626	Chpt. 111. Sec. 4446 Petitioner has complied with all terms and conditions.	Restoration 80-50	8-19-80
W. John Borak 2640 S.W. 22nd Street Room 1104 Delray Beach, Florida MEDICAL DOCTOR	Chpt. 111, Sec. 4446 No evidence was presented as to his competence to resume his profession.	Petition for Restoration Denied 80-1	7-8-80
Edward Barkdull 502 West St. Louis West Frankfort. IL MEDICAL DOCTOR 36-26630	Chpt. 111, Sec. 4446 Petitioner has complied with all terms and conditions.	Restoration of Controlled Substances License Schedule II 80-49	8-19-80
Aldona Nakutis c/o Shea & Heth, Ltd. 2135 S. Maple Avenue Berwyn, IL 60402 MEDICAL DOCTOR 36-35374 44-827	Chpt. 111, Sec. 4433 Petitioner presented sufficient evidence to prove rehabilitation and good moral character	Restoration with 2 years Probation 79-77	10-3-80

Pulse of the ISMS Auxiliary

From the Desk of the President

COMING EVENTS

By Bonnie Keegan, ISMSA President

Physicians and physicians' spouses take note! Clip this page and add to your calendar of important events.

Thursday, September 17
ISMSA Leadership Seminar-South
Centralia

Friday, October 9
ISMSA Leadership Seminar-North
Chicago

Saturday, October 10
Open to ALL
ISMSA Fall Conference
Wilmette
"Fun, Fitness, and Information"

October 11, 12 and 13, Drake Hotel
AMAA Confluence (County Pres.-elects)
Chicago

Friday, November 6, Springfield Hilton
ISMSA Leadership Seminar-Central
Springfield

Saturday, November 8, Springfield Hilton
ISMSA Fall Board Meeting
Springfield

November 6-8 Springfield Hilton
ISMS Board and House of Delegates
Springfield

Monday, January 18, 1982 Palmer House Hotel
ISMSA Convention Committee Meeting
Chicago

Tuesday, January 19, 1982,
Rehabilitation Institute
ISMSA Board Meeting
Chicago

April 17 thru 21, 1982, Palmer House Hotel
ISMS and ISMSA Annual Meeting
Chicago.

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*To participate in free leadership training and educational seminars

*To improve health care and medical practice by impacting legislation

*To provide financial assistance to medical students, interns, and residents

*To support important scientific and medical research.

AMA AUXILIARY

Viewbox

(Continued from page 81)

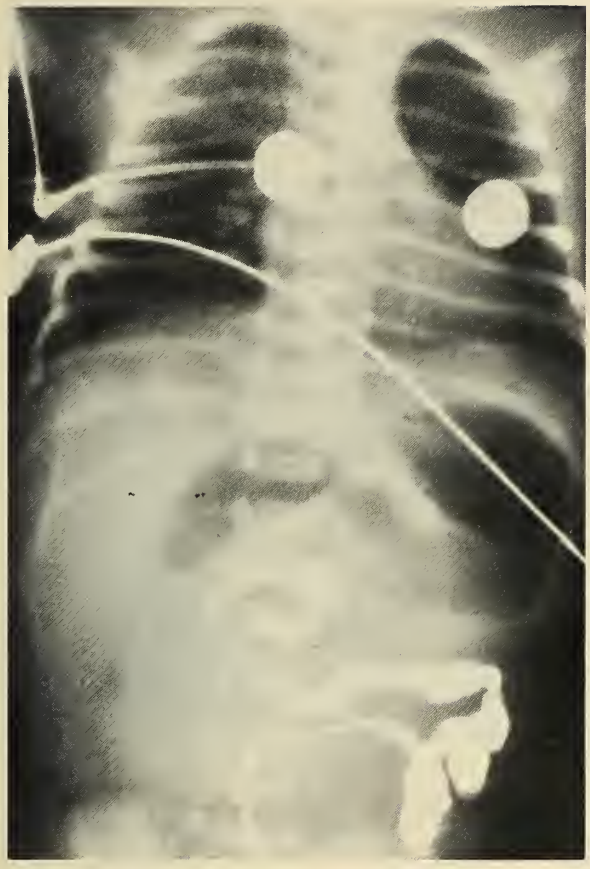


Figure 2A—Patient 2
Abnormal midline position of the cecum.



Figure 4A—Patient 4
There is microcolon.

Diagnoses:

Patient Figure 1—Plain film findings indicate a markedly distended stomach and duodenum with no distal GI tract air. This is the classic double bubble of *duodenal atresia.*

Patient Figure 2—Plain film findings indicate a corkscrew configuration of bowel loops in the LUQ indicative of *midgut volvolus.* The BE findings (Figure 2A) indicate a malpositioned cecum overlying the spine.

Patient Figure 3—Plain film findings show calcification in the right abdomen with distended bowel loops indicative of *meconium peritonitis* with bowel obstruction.

Patient Figure 4—Plain film findings include a dilated loop of small bowel along with dilatation of the stomach and duodenum without distal air. The BE findings indicate a microcolon (Figure 4A). The UGI indicates a dilated stomach and duodenum with a dilated proximal jejunum indicative of *jejunal atresia.*

Table 1 demonstrates that a large number of problems can cause neonatal obstruction of the stomach, duodenum, and small bowel.
In most cases, diagnosis and location of an obstruction can be made by evaluating clinical and roentgenographic information. To accurately assess the patient and localize the site of obstruction, several radiographs of the abdomen are recommended. The easiest to obtain are the AP upright, AP supine, and cross table lateral supine films.[1]

Duodenal obstruction is much more frequent in the neonate than gastric obstruction. A common cause of duodenal obstruction are *peritoneal bands.* The most frequent type are Ladd's bands, which are often associated with malrotation and midgut volvulus.[1,2] The bands extend from the malpositioned cecum to the right posterolateral

Table 1
Causes of Neonatal Obstruction Proximal to the Colon[1]

STOMACH
- Gastric web
- Gostric volvulus
- Gastric outlet obstruction
 - —hypotonio
 - —pylorospasm
- Gastric membrone
- Duplicotion
- Gostroduodenol intussusception
- Loctobezoor

DUODENUM

Instrinic
- *Atresia
- Stenosis
- *Incomplete diaphrogm
- Duplicotion
- Agonglionosis
- Hemotomo
- Absence of duodenal musculature

Extrinsic
- *Midgut volvulus
- *Bonds with or without molrotation
- Preduodenol portol vein
- Cholecystitis
- *Annulor pancreos

SMALL BOWEL
- *Atresio
- Stenosis
- *Meconium ileus
- Totol colon Hirschsprungs
- Duplication
- Volvulus
- Bands
- Meckel's diverticulum
- Infarct 2^0 to UA cotheter
- Stricture secondory to necrotizing enterocolitis
- Intussusception
- Diophrogm
- Mesenteric cyst
- Internal hernio
- Idiopothic segmentol dilototion
- Inspissoted milk syndrome



Figure 5
The cecum is located in the LUQ in this patient with malrotation.

abdominal wall. They course over the third and fourth portions of the duodenum and cause various degrees of obstruction.[3]

Signs of obstruction do not occur in all infants, but if obstruction presents in the neonatal period it frequently occurs in the first week of life. Bilious vomiting occurs and the abdomen is flat.[1,2] Plain film findings include a normal or mildly dilated duodenal bulb with varying amounts of air in the distal bowel.[2] The need for contrast studies depends upon the degree of obstruction. In cases of complete duodenal obstruction, most feel that opaque studies are unnecessary. If surgery is to be delayed, however, an enema can be performed to rule out a malrotation.[1,4] Cecal position in the midline or left upper quadrant indicates malrotation. (Figure 5) High cecal position in the right upper quadrant, however, is normal in the neonate.[4]

In cases of incomplete duodenal obstruction many feel that an opaque enema should be performed because of the possibility of associated midgut volvulus. (A malpositioned cecum indicates malrotation.) Others feel that an UGI should be performed since malrotation with duodenal obstruction can be found with normal position of the cecum. An advantage of the UGI is actual demonstration of the site of obstruction.[1,4] (Figure 6)

Malrotation of the gut predisposes to volvulus because of the presence of a short mesenteric root. Clinical signs occur in the first week of life and are commonly intermittent. Occasionally, symptoms recur for years prior to diagnosis. The ab-



Figure 6
An obstruction is evident in the third portion of the duodenum and was due to peritoneal bands.

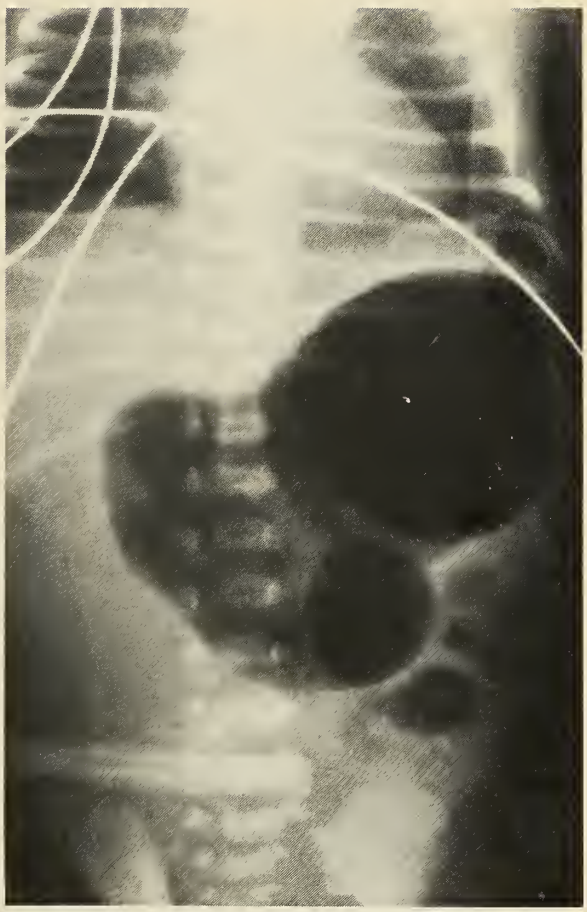


Figure 7
Findings include dilatation of the stomach and duodenum with air in LUQ bowel loops due to malrotation with volvulus.

domen is flat and there is bilious vomiting. X-ray findings include duodenal dilatation plus some air in the small bowel. (Figure 7) Barium enema will demonstrate a malpositioned cecum but an UGI will demonstrate the site of obstruction. Findings on UGI include: (1) abnormal location of the proximal small bowel loops; (2) duodenal dilatation with tapering distally and (3) spiral or corkscrew configuration of the upper jejunum.[2]

Volvulus may be complicated by ischemia and is suggested by blood in the stool or vomitus and clinical deterioration. X-ray findings include pseudotumor caused by fluid filled bowel loops, intramural gas, pneumoperitoneum, gasless abdomen, or mucosal irregularity. Prompt surgical intervention is mandatory.[1]

Duodenal atresia, usually perimpullary, is another cause of duodenal obstruction. Atresia has a higher incidence in Down's syndrome.[3] Clinical symptoms occur within the first 24 hours of life. There is bile stained vomitus, a flat abdomen, and absent or abnormal passage of meconium. The classic radiographic appearance is the double bubble sign with dilatation of both the duodenal bulb and stomach. There is no air distally in the intestine.[4] If the child has recently vomited, 10-15cc of air can be injected through a nasogastric tube to better delineate the duodenum and stomach. Contrast studies are unnecessary prior to surgery if complete obstruction is shown on plain films. The rare occurrence of a bifid bile duct with one limb proximal and one limb distal to the obstruction allows air to enter the small bowel simulating incomplete obstruction. Distal air will also be present with duodenal stenosis.[4]

Annular pancreas is often listed as a cause of duodenal obstruction, but because of the nearly constant association of intrinsic obstruction of

the duodenum, many feel that annular pancreas in itself is not the cause of the obstruction. X-ray findings are usually those of partial duodenal obstruction.[1,2,4] (Figure 8) Clinical findings are variable depending upon the degree of obstruction. Many patients are not diagnosed until adulthood. Diagnosis is seldom possible preoperatively.

Duodenal diaphragm is an infrequent cause of duodenal obstruction and can be missed at the time of surgery if not specifically sought. Diaphragms are found in 10% of patients with extrinsic obstruction due to peritoneal bands.[4] The diaphragm is most commonly located post ampullary. As in other causes of duodenal obstruction, associated malformations (TE fistula, esophageal atresia, anorectal anomaly, and congenital heart disease) may be present.[1,4]

Clinical signs depend upon the size of the diaphragmatic opening. With a small opening, symptoms may be similar to atresia, but if the opening is large, symptoms may be delayed in appearance for months or years. The late outcome is an intraluminal diverticulum in an adult.[1,4]

The radiographic appearance varies from normal to that of an incomplete duodenal obstruction. When obstruction is incomplete an UGI is indicated. The duodenal dilatation is severe with a characteristic rounded contour of the distal segment. Passage of contrast is delayed.[4] The definitive diagnosis of a diaphragm can be made if there is demonstration of the wall of the diaphragm as a thin lucent line, but this finding is rare in the neonate. Treatment consists of surgical resection of the diaphragm.[1]

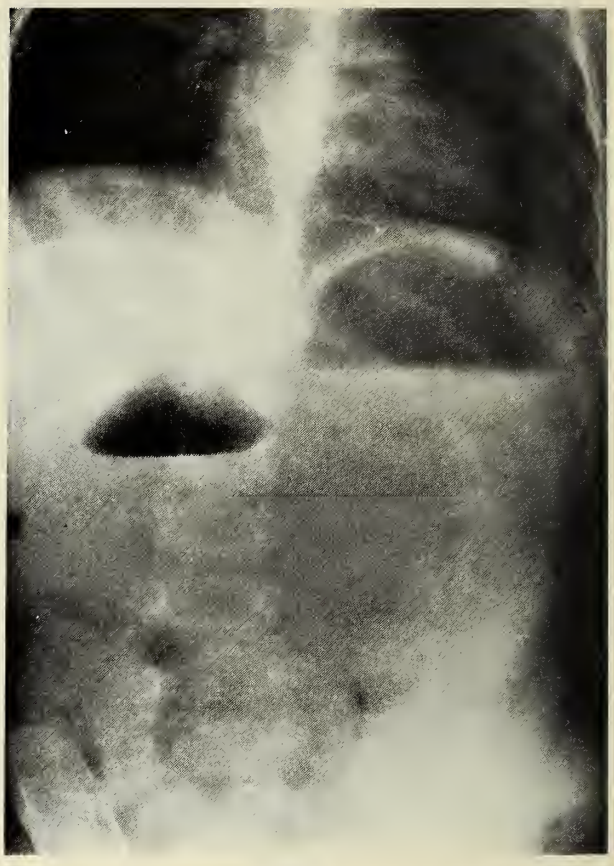


Figure 8
The film shows a double bubble with some air in the distal bowel indicative of an incomplete duodenal obstruction.

Small bowel obstruction is found secondary to congenital defects in one out of 1500 infants.[4]

Small bowel atresia occurs without predilection for the jejunum or ileum. There may be multiple sites of atresia.[4,5] Atresia of the small bowel is felt to be due to bowel ischemia occurring late in fetal life. This is in contrast to duodenal atresia which is due to a failure of recanalization of the duodenum early in fetal life.

Clinical symptoms occur in the first few days of life and consist of bilious vomiting and abdominal distention. There can be normal passage of meconium since the atresia develops late in fetal life.[4]

Plain film X-ray findings include marked dilatation of the intestine with air fluid levels. Greater numbers of air fluid levels are present with more distal obstructions. The presence of a microcolon suggests the presence of a complete small bowel obstruction close to the colon. Diagnosis is fairly easy when there is atresia with only a few dilated loops of bowel, but low ileal occlusion can mimic other diseases such as meconium ileus. The presence or absence of microcolon depends upon the time the obstruction occurred in fetal life and its location. If obstruction is high in the small bowel or occurs late in fetal life, the colon can be normal because of meconium formed distal to the atresia.[4]

Meconium ileus occurs in 10% of patients with cystic fibrosis. In addition, most patients with meconium ileus also have cystic fibrosis.[4] The obstruction is due to the increased viscosity of the meconium which causes obstruction in the distal ileum.

Clinically there is abdominal distention and vomiting. Complications are frequent (50% of cases) and include volvulus, small bowel atresia, meconium peritonitis, and pseudocyst formation.

Meconium ileus or ileal atresia can also cause meconium peritonitis. Intra-abdominal calcifications are usually residuals of intestinal perforation which occurred *in utero.* [1,2,4]

X-ray findings in the uncomplicated meconium ileus include non-uniformly distended loops of bowel with few if any air-fluid levels. If air-fluid levels are present, they are curvilinear rather than horizontal. A bubbly appearance due to gas mixed with meconium can be seen in the RLQ.[1,2,4]

Diagnosis is confirmed by a contrast examination of the colon to exclude rotational anomalies and colonic obstruction, but an enema should not be performed if there are signs of a complication. Recommended agents are Gastrografin or Hypaque.[1,2] Findings include microcolon, round defects in the distal ileum, and distended ileal loops more proximally. Before and after the enema, fluid balance is critical as the water soluble agents are hyperosmolar. The water soluble agent and its wetting agent may be used to relieve the obstruction. Repeated fillings may be necessary to dislodge the inspissated meconium.[2]

Intussusception is another cause of bowel obstruction but is rare in the first few weeks of life. Two-thirds of the cases are ileocecal.[1] In the neonate the cause is usually secondary to a leading point, while later in childhood intussusception is usually idiopathic.[4] Clinically the signs are those of obstruction, which may be complicated by intestinal ischemia. X-ray findings include obstruction, lack of RLQ gas, and colon gas outlining a mass. A barium enema may be necessary to make the diagnosis. Some authors recommend water soluble contrast for the enema study because of the risk of perforation. Surgery is necessary due to the high incidence of a leading point in the neonate with intussusception.[1] ◀

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3. Swischuk, L.E.: *Radiology of the Newborn and Young Infant.* Williams & Wilkins, Baltimore, 2nd Ed., 1980.
4. Franken, E.A.: *Gastrointestinal Radiology in Pediatrics.* Harper & Row, New York, 1975.
5. Touloukion, R.J.: "Intestinal Atresia," *Clin. in Perinatology* 5:1, March, 1978.

THE PROBLEM

To invent a 48 hour day and a physician who can be in two places at the same time.

THE ANSWER

A Physician Assistant

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

AURORA: Population 85,000-opening for cardiologist in well-established group of 45 physicians. Excellent hospital and clinic space available. Located 50 miles from downtown Chicago on E/W Tollway. CONTACT: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506 (312-859-6700). (12)

CHICAGO: Family practitioner, dynamic two doctor urban practice. Comprehensive ambulatory emphasis. Nearby hospital privileges include OB. Far south Chicago, ethnic, blue collar community. Spanish desirable. CONTACT: T. Kearney, M.D., Claretian Medical Center, 2945 E. 91st St., Chicago 60617 (312-768-5000). (8)

CLIFTON: Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

DU QUOIN: Opportunities for solo or group practice in well known small community. St. Louis 75 miles. S.I.U.-Carbondale 25 miles. Excellent schools, churches, shopping, housing and recreation. JCAH hospital specializing in quality care. Du Quoin and Marshall Browning Hospital would love to tell you more. Call David R. Hosler, Adm., collect at 618-542-2146. (12)

EDWARDSVILLE: Practice opportunity available in area with over 10,000 population near St. Louis, Mo. Two FP planning retirement. CONTACT: J. C. Collins, Jr., M.D., 325 S. Kansas St., Edwardsville 62025. (618-656-1048). (9)

EL PASO: Population 2700. Family Practice available immediately. Fully equipped office. Excellent schools, churches and hospitals. Contact R. P. Lykkebak, M.D., El Paso 61738. Phone (309) 527-4007. (9)

FAIRBURY: Thriving family practice opportunity available as third physician of well-established group. Progressive rural community near urban areas. Well-equipped, JCAH accredited, 112 bed hospital offers income guarantees and other financial assistance. Send CV in confidence to: F.A. Brady, Adm., Fairbury Hospital, 519 S. 5th St., Fairbury 61739. (8)

FAIRBURY: Family Practice Physician to join fast growing practice in thriving rural area. Well-equipped, JCAH accredited, 112-bed hospital offers income guarantees and other financial assistance. Send Curriculum Vitae in confidence to Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (12)

FREEPORT: Otolaryngologist, Cardiologist, Gastroenterologist, General Internist, Family Practice, Urologist—to join expanding 20 physician multi-specialty Clinic. This 30 yr. old group practices in a new facility across from a recently expanded general hospital in a community of 30,000. CONTACT: C. Wm. Metcalf, M.D., Medical Director, Freeport Clinic, S.C., 1036 W. Stephenson St., Freeport 61032, 815-235-5111. (12)

GRIGGSVILLE: Become only full-time physician in combined trade area of 7,000. Take over big practice of physician recently killed in accident. Industrial growth community in beautiful Illinois River area. 100 miles north St. Louis; 70 from Springfield. CONTACT; Helen Rumple, Griggsville, 62340, 217-833-2521 or 833-2792. (12)

HERRIN: Service area with population of 40,000. 15 miles from Southern Illinois University, 100 miles from St. Louis. Located in ideal vacation land, with many lakes and parks. Modern 130 bed hospital with primary care staff of 17 physicians. Financial assistance available. CONTACT: Larry Feil, Herrin Hospital 201 S. 14th Street, Herrin, 62948 618-942-2171. (12)

MINONK: Practice opportunity available for GP located in Central Illinois-population 2,400. Three open staff hospitals in vicinity. General practicioner interested in retiring. CONTACT: K Vaicius, M.D., 511 Oak St. Minonk 61760 (309-432-2781 in PM). (12)

MT. CARMEL: Population 9,500, located halfway between Evansville and Vincennes, Indiana on the Illinois border. Mt. Carmel is a community presently undergoing aggressive physician recruitment efforts and building a new hospital. Through the hospital, financial assistance is available and complete office facilities are provided. Contact Cliff Bauer, 1418 College Drive, Mt. Carmel, Illinois 62863, phone AC (618) 262-4121. (12)

MT. CARMEL: Wanted pediatrician or family practitioner to replace retired physician. Office ready to go. Solo or joint with another physician. CONTACT: B. G. Lambos, M.D., 101 Broad St., Lanark, 61046 (815-273-3323). (8)

PARIS: Practice opportunity available. Physician (FP) planning to retire is interested in someone to take over practice. Population area over 10,000. Modern hospital facilities and complete office available. CONTACT: Dr. G. M. Churukian, 406 S. Main St., Paris 61944. (217-463-4560). (9)

PONTIAC: Associate in my local downtown office building. Great need for qualified Orthopedic Surgeon or Associate in Family Practice. Could be renting separate office or my same large 2-man designed office space. Economic association, partnership or rental could be arranged, mutually. Long-standing 60 year practice established by father. Contact H.C. Parkhill, M.D., 202 N. Main St., Pontiac 61764 or AC 815-844-6148. (9)

SAVANNA: Practice Opportunities—FP's and Internal Medicine Specialists. Join progressive health care center in delightful small town community. Complete office facilities, immediate access to hospital. Financial assistance available. Hunting, fishing, water-sports paradise. CONTACT: Darrell Milner, Savanna/Carroll County Health Services, 333 Chicago Avenue, Savanna, 61074; Phone (815) 273-2287. (12)

SYCAMORE:-Associate desired-for July 1982-Family Practice opening to join two FP, internist, and surgeon in a newly formed group, situated 70 miles west of Chicago in a semi-rural area. Family Practice oriented hospital with full privileges. Equal partnership after 24 months; salary and fringe benefits open to negotiation. Send full CV to : Irving Frank, M.D., 954 W. State St., Sycamore, IL. 60178. (12)

WAUKEGAN: Plant Physician Wanted. Responsibilities include services to occupational disease and injury cases, physical examinations, evaluation of disability cases and advising management on medical matters. Excellent benefit package available. Salary negotiable. Please contact J.W. Szcygielski, Employee Relations Manager, Johns-Manville Sales Corp., Greenwood Avenue, Waukegan 60087. (AC 312) 623-2900 EXT 213. (12)

Doctor's News

PHYSICIANS IN THE NEWS—Newly elected officers of the Chicago Medical Society are **Robert C. Hamilton, M.D.**, Chicago, president; **Alfred J. Clementi, M.D.**, Palatine, president-elect and **Richard H. Blankshain, M.D.**, Oak Park, secretary. Re-elected to their posts as CMS officers are **John P. Harrod, Jr., M.D.**, Chicago, treasurer; **Harold J. Lasky, M.D.**, Evanston, chairman of the CMS Council and **Harry A. Springer, M.D.**, Evanston, vice chairman of the Council.

Richard C. Shaw, M.D., Chicago, resigned as vice president and medical director of the Illinois Blue Cross/Blue Shield Corporation to accept a position with the Maine Blue Cross/Blue Shield Plan Newly named officers of the Aux Plaines Branch of the Chicago Medical Society are **James H. Andersen, M.D.**, president; **Frank DeTrana, M.D.**, vice president; **Marshall Short, M.D.**, secretary and **Alberto Rodriguez, M.D.**, treasurer.

Newly named fellows of the American College of Radiology include **Jen-hung Chao, M.D.**, Chicago; **James Joseph Conway, M.D.**, Chicago and **Richard Lee Phillips, M.D.**, Park Ridge.

The 1980-81 officers of the Chicago Dermatological Society are **Sylvia Griem, M.D.**, president; **Frank Dunlap, M.D.**, president-elect; **Fred Levit, M.D.**, vice president and **Marianne O'Donoghue, M.D.**, secretary-treasurer.

Newly elected officers of the Illinois Academy of Family Physicians include **John E. Meyenberg, M.D.**, Chicago, president-elect; **Robert Swastek, M.D.**, Chicago, chairman of the board; **Raymond Rowlette, M.D.**, Chicago, treasurer; **Harry Marchmont-Robinson, M.D.**, Oak Brook, executive director; **Lawrence L. Hirsch, M.D.**, Chicago, delegate and Chicago physicians **Philip Anderson** and **Dolores Lulinski-Dybalski**, directors.

M. Barry Kirschenbaum, M.D., Chicago, has been elected president of the Illinois Dermatological Society Chicago physicians named to advisory panels of the U.S. Pharmacopeial Convention Committee on Revision, which will provide input for USP Drug Information Division programs, are **Arthur L. Herbst, M.D.**, named to the Advisory Panel on Endocrinology and **Harold L. Klawans, M.D.**, named to the Advisory Panel on Neurological and Psychiatric Disease.

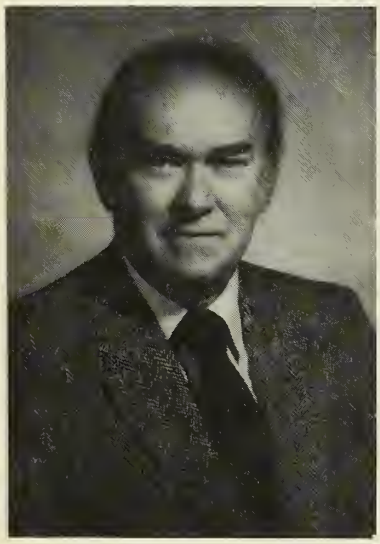
Newly named fellows of the American College of Physicians include **Ismail Atcha, M.D.**, **William D. Barnhart, M.D.**, **Peter Bright-Asare, M.D.** and **Jack M. Bulmash, M.D.**, of Chicago; **John F. Moran, M.D.**, Burr Ridge; **Wei-Tzuoh Chen, M.D.**, and **Mushtaq A. Khan, M.D.**, Downers Grove; **Paul A. Breenberger, M.D.**, and **Sam J. Suger, M.D.**, Evanston; **Anthony L. Barbato, M.D.**, Oak Park; **Subhash Popli, M.D.**, Oak Brook and **William J. Arnold, M.D.**, Park Ridge.

Eugene F. Diamond, M.D., Maywood, received the first George Award in Clinical Pediatrics. The Award, which will be given annually by the Illinois Masonic Medical Center, recognizes excellence in pediatric practice and service to children **William N. Spellacy, M.D.**, Chicago, has been elected president of the Association of Professors of Gynecology and Obstetrics Newly named officers of the Ravenswood Hospital Medical Center medical staff are **Harry H. Hetz, M.D.**, Kenilworth, president; **Thornton A. Davis, M.D.**, Skokie, vice president and **Marcelo Munoz, M.D.**, Skokie, secretary-treasurer.

Former ISMS President **Frank J. Jirka, Jr., M.D.**, Barrington, has announced candidacy for the office of AMA president-elect in 1982. The ISMS Board of Trustees has voted vigorous support of Dr. Jirka's campaign. At present, he is serving a third term on the AMA Board of Trustees, where he has held positions of secretary, secretary-treasurer and vice-chairman. Dr. Jirka is also a former trustee and board chairman of ISMS, Chicago Medical Society Douglas Park Branch president, CMS councilor and ISMS delegate.

The Illinois Medical Disciplinary Board recently elected their new officers. **James B. Williams, M.D.**, was re-elected chairman of that body; **John Gregorio, M.D.**, River Forest, was elected vice chairman and **Helen R. Beiser, M.D.**, Chicago, was named secretary.

President's Page



Together

Although specialty societies have individual needs that require unique efforts and solutions, specialty groups also have many problems in common with medical societies—particularly at the state level.

The most common problem is the constant barrage of legislative challenges which medicine, in all of its specialties, must face on an almost daily basis. Only through current and valid information can specialty society officers hope to develop effective strategies to respond to these legislative challenges.

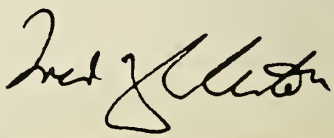
While ISMS officers and staff are constantly involved in legislative negotiations, individual specialties must respond only to intermittent challenges. Nonetheless, the ability to deal with these occasional issues depends upon the specialty societies' up-to-the-minute awareness of what is happening in the General Assembly and the resulting activities of ISMS and other medical associations.

Obtaining such information is difficult. Legislative activities will not always warrant full-time staffing by the individual society, and communication with ISMS is not always as rapid as necessary.

The ideal solution—particularly for societies of smaller memberships—would be to follow the lead of the Illinois Psychiatric Society; Illinois Association of Ophthalmology; Illinois Society of Internal Medicine; Illinois chapter, American Academy of Pediatrics; Illinois Radiological Society and Illinois Dermatological Society who have entered into staffing agreements with ISMS. Aside from other practical issues of cost effectiveness and efficiency of operations, such agreements have allowed for instant communication between our staffs, improved liaison among our leadership and a concerted effort in Springfield.

A concerted voice with an informed leadership is our best opportunity to remain an effective legislative force in Springfield. Although we know that we are together philosophically and practically, we dilute our effectiveness if the General Assembly hears different voices from different lobbyists or groups of physicians—even if those voices are saying the same thing.

The potential for effectiveness through this concerted effort is great. It should be worth exploration by the leadership of specialty societies who have not yet taken advantage of the opportunities offered by the Illinois State Medical Society. ◀



Fred Z. White, M.D., President

IMPAC

ILLINOIS MEDICAL POLITICAL ACTION COMMITTEE
55 East Monroe Street
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312/782-1963

NONPARTISAN

WHAT IS IMPAC, DOCTOR? IMPAC IS YOU.

It is YOU and your colleagues throughout the state becoming involved in the democratic process called "politics."

It is YOU becoming familiar with the issues affecting medicine and how your elected representatives stand on them.

It is YOU feeding information to your political action committees, information which helps determine which candidates IMPAC will support in an effective, coordinated way.

It is YOU forming local support groups for those candidates who best represent your point of view and then backing those candidates with voice, votes and financial assistance.

It is YOU who will implement the action locally when the decisions are reached at the state and national level. What is IMPAC?

It is YOU, Doctor, practicing American democracy. There is no guru in Valhalla; no brilliant leader in Springfield or Washington directing you. It is you directing your committee from HOMETOWN, Illinois... It is up to YOU.

ISN'T IS ABOUT TIME YOU JOINED THE ILLINOIS STATE MEDICAL SOCIETY POLITICAL ACTION COMMITTEE?

We must help elect people who are both aware of the current crisis in health care legislation and ready to back our stand. IMPAC supports only people who are approved by the physicians in their area. IMPAC is nonpartisan. IMPAC supports Republicans and Democrats, Conservatives and Liberals. IMPAC confines its limited funds to backing only critical races.

IMPAC ACTS WITH YOU - JOIN IMPAC - JOIN TODAY.

P.F. Mahon MD

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Chairman

Contributions ere not limited to the suggestad emount. Neither tha Illinois Stata Medical Sociaty nor the AMA will favor or disadvantage anyone basad upon tha amounts of or failure to make pec contributions. Contributions ere subject to the limitations of FEC regulations, Saotions 110.1, 110.2, &110.5. (Federel Ragulations requira this notica.) IMPAC reports are filed with the State Board of Elactions, and are or will ba avellable for purchase from the State Board of Elactions, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support polltioal ection committae mambership in IMPAC for candidates for public offica in Illinois and candidates for fedaral office alsewhare through AMPAC.

Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603; (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

SEPTEMBER

Anesthesiology

Illinois Society of Anesthesiologists Downstote Meeting
For: Anesthesiologists. Symposium, Sept. 19, Springfield. **Sponsors:** Illinois Society of Anesthesiologists; SIU School of Medicine, c/o Robert Boettner, MD, P. O. Box 3926, Springfield 62708. **Reg. deadline:** 9/10. **Fee:** $25, members; $30, non-members; students, $10. **Credit:** Category 1, 5 hours. **Contact:** Robert Boettner, MD. **Phone:** 217/782-8883.

Cardiology

Cordiology Boord Review Course
For: MD's. Course, Sept. 16-19, Knickerbocker Hotel, Chicogo. **Speaker:** Leon Resnekov, MD. **Sponsor:** American College of Chest Physicions, 911 Busse Hwy., Pork Ridge 60068. **Reg. deadline:** none. **Reg. limit:** none. **Fee:** $300, members; $350, non-members. **Credit:** Category 1, 29 hours. **Contact:** Dale Braddy. **Phone:** 312/698-2200.

Dermatology

Speciolty Review in Dermatology
For: Dermatologists. Lecture, Sept. 14 (5 days), Chicago. **Speoker:** Marsholl Blonkenship, MD. **Sponsor:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $350. **Reg. limit:** 75. **Credit:** Category 1, 34 hours. **Contact:** Robert 8aker, MD. **Phone:** 312/733-2800.

Gynecology

Gynecologicol Loporoscopy
For: Gynecologists. Lecture, Sept. 2 (3 doys), Chicago. **Speaker:** John Borton, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 8. **Credit:** Category 1, 18 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Infectious Disease

Infectious Diseose
For: MD's. Seminor, Sept. 30, 8:00 a.m., Waukegan. **Speoker:** Stu Levin, MD. **Sponsor:** St. Therese Hospital, 2615 Woshington, Woukegan 60085. **Reg. deadline:** 9/28. **Reg. limit:** none. **Fee:** none. **Credit:** Category 1, 3 hours; AAFP Prescribed, applied for. **Contact:** R. M. Adelmon, MD, DDS. **Phone:** 312/578-2555.

Internal Medicine

Specialty Review in Medical Oncology
For: Internists, Oncologists. Lecture, Sept. 8 (5 days), Chicago. **Speoker:** John Merrill, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 150. **Credit:** Category 1, 40 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Internal Medicine

Speciolty Review in Endocrinology
For: Internists, Endocrinologists. Lecture, Sept. 14 (5 doys), Chicago. **Speoker:** Sheldon Woldstein, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 150. **Credit:** Category 1, 40 hours. **Contact:** Robert 8aker, MD. **Phone:** 312/733-2800.

Internal Medicine

Speciolty Review in Gostroenterology
For: Internists, Gastroenterologists. Lecture, Sept. 21 (5 days), Chicogo. **Speoker:** Ruven Leviton, MD. **Sponsor:** Cook County Groduote School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 150. **Credit:** Category 1, 40 hours. **Contact:** Robert Boker, MD. **Phone:** 312/733-2800.

Internal Medicine

Internol Medicine of the 1980's
For: Internists, FP's, GP's. Workshop, Sept. 21-23, Chicago. **Speoker:** Ruy Lourenco, MD. **Sponsor:** U of I, CME, 1853 W. Polk St., Rm. 144, Chicago 60612. **Reg. deadline:** 9/7. **Reg. limit:** 200. **Fee:** $250. **Credit:** Category 1, 18 hours; AAFP Elective, 18 hours. **Contoct:** Sue Korienek. **Phone:** 312/996-8025.

Internal Medicine

Speciolty Review in Cordiovosculor Diseose
For: Internists, Cardiovoscular Specialists. Lecture, Sept. 8 (5 doys), Chicogo. **Speaker:** John Demakis, MD. **Sponsor:** Cook County Groduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $400. **Reg. limit:** 300. **Credit:** Category 1, 40 hours. **Contoct:** Robert Boker, MD. **Phone:** 312/733-2800.

Medicine

Breast Cancer Updote
For: Physicians, Surgeons. Lecture, Sept. 25, 8:00 o.m., Chicago. **Speoker:** 8arry Goldsmith, MD. **Sponsor:** Grant Hospital, 550 West Webster St., Chicago 60614. **Fee:** none. **Credit:** Category 1, 1 hour. **Contact:** Robert Mutterperl, DO.

Medicine

Clinical Refresher Course
For: GP's. Course, Sept. 23-26, Chicago Morriott Hotel. **Sponsor:** Chicogo College of Osteopathic Medicine, 5206 S. University Ave., Chicago 60615. **Reg. deadline:** 9/22. **Fee:** $200. **Reg. limit:** none. **Credit:** AOA, 21 hours. **Contoct:** Morie Kowalsky. **Phone:** 312/947-4600.

OB/GYNE

Specialty Review in Ob-Gyne: Proctical Aspects
For: Obstetricians, Gynecologists. Lecture, Sept. 14, (5 1/2 days), Chicago. **Speoker:** M. LeRoy Sprong, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicogo 60612. **Fee:** $425. **Reg. limit:** 300. **Credit:** Cotegory 1, 44 hours. **Contoct:** Robert Baker, MD. **Phone:** 312/733-2800.

Pediatric Infectious Disease

Pediotric Infectious Disease Conference
For: MD's. Lecture, Sept. 9, Park Ridge. **Speoker:** Heinz Eichenwald, MD. **Sponsor:** Lutheran General Hospital, 1775 Dempster St., Park Ridge 60068. **Reg. deadline:** 9/2. **Fee:** $50, Attendings; $20, Residents. **Reg. limit:** 300. **Credit:** Category 1, 6 hours. **Contoct:** Seymour Metrick, MD. **Phone:** 312/696-6986.

Pediatric Neurology

Pediotric Neurology in Doily Clinical Practice
For: MD's. Seminar, Sept. 30, Maywood. **Sponsor:** CME, Loyola University of Chicago, Stritch School of Medicine, 2160 S. First Ave., Maywood 60153. **Fee:** $125. **Credit:** Category 1, 6 hours; AAFP Prescribed, 6 hours. **Contact:** Lindo Gunzburger, PhD. **Phone:** 312/531-3236.

Surgery

Fiberoptic Colonoscopy
For: Surgeons, Internists, FP's. Lecture, Sept. 30 (2 1/2 days), Chicago. **Speoker:** Herond Abcorian, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 45. **Credit:** Category 1, 15 hours. **Contact:** Robert 8oker, MD. **Phone:** 312/733-2800.

EVALUATION OF CME PROGRAMS—
A New Two-Day Workshop from ICCME
October 9-10, 1981
Oak Brook Hyatt Hotel, Oak Brook, IL

This Workshop—the first of a new and challenging series—will help you gain practical understanding of (1) the role of comprehensive evaluation in CME planning, and (2) various evaluation techniques appropriate for CME programs.

The Workshop is designed especially for physicians responsible for planning and implementing CME programs for their colleagues—DME's, chairmen and members of program/education committees, medical directors, department/service chiefs, medical school faculty—as well as non-physician CME planners/coordinators who are actively involved in planning CME programs, and education specialists with advanced degrees seeking more background on physician learning.

Registration is limited to 24. Learning activities include small-group discussion and problem solving, individual work on specific problems, and faculty comments on major considerations of evaluation.

For details, write or call . . .

Illinois Council on Continuing Medical Education
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WANTED: INSTRUCTOR/ASSISTANT PROFESSOR OF PEDIATRICS—For half time position in ambulatory and continuity care at Mercy Hospital and U. of Illinois Hospital. Illinois license and Board eligibility required. Salary $22,500. Contact: Billie Adams M.D., Clinical Associate Professor of Pediatrics, Mercy Hospital Medical Center, Stevenson Exy., King Drive, Chicago, IL 60616. (312) 567-2156. Application deadline: September 1, 1981. An equal opportunity/affirmative action employer m/f/h.

EMERGENCY MEDICINE—West Central Illinois: Directorship and staff opportunities in moderate volume ED. Physicians chosen will receive an excellent compensation, be provided with professional liability insurance, have flexible hours without on-call impositions, and receive bonus for CME. For details, send credentials in confidence to Michelle Grimm, 970 Executive Parkway, St. Louis, MO 63141; or call toll free, 1-800-325-3982.

EMERGENCY MEDICINE—Central Illinois University Town: Staff positions available in moderate volume emergency department. University setting provides for numerous recreational, educational, and cultural facilities and activities. Physicians will receive an excellent income, paid liability insurance, and flexible scheduling without on-call duty. For details, contact Michelle Grimm, 970 Executive Parkway, St. Louis, MO 63141; or call toll-free, 1-800-325-3982.

WANTED—PRIMARY CARE PHYSICIAN licensed in Indiana to practice in university 38-bed JCAH Accredited Hospital with large outpatient clinic. Must be able to communicate with and have empathy toward the college age population. Begin September 1, 1981; salary negotiable; excellent fringe benefits. Contact personally or send resume to Thomas A. Schott, Administrator, Purdue University Student Hospital, West Lafayette, Indiana, 47907; 317-749-2441. An equal opportunity/affirmative action employer.

PHYSICIANS WANTED—For immediate openings in many Sunbelt and Midwest practices and clinics. Salaries and benefits excellent. Positions for: Family Practice and Anesthesiology. Call Dr. Robb Montgomery, Director of Services in Physician Placement Assistance, MEDI-SEARCH (918) 481-0539, 8117 S. Harvard, Tulsa, OK 74136.

CHICAGO EMERGENCY MEDICINE: Directorships and staff positions available in two moderate volume emergency departments located in the metro Chicago area. Board certification or eligibility in Emergency Medicine required. Excellent compensation, flexible scheduling. Contact Michelle Grimm toll-free, 1-800-325-3982; or send credentials in confidence to 970 Executive Parkway, St. Louis, MO 63141.

MULTISPECIALTY GROUP thirty miles southwest Chicago seeks young family practitioner willing to do Obstetrics and Ob-Gyn man to join expanding practice. Incentive plan, profit sharing, new building. Excellent practice opportunity and schools. Contact Howard Osmus, Administrator, Hedges Clinic, Frankfort, IL 60423. (815-469-2123)

PSYCHIATRIST with interest and experience in alcohol and other drug abuse to join staff of comprehensive Chemical Dependence Program in large university-affiliated hospital in major urban center. Faculty appointment in Northwestern University Medical School. Illinois license required. Salary negotiable. Send C.V. to Gilbert Hefter, M.D., Clinical Director, Northwestern Memorial Hospital, Institute of Psychiatry, 320 East Huron Street, Chicago, Illinois 60611. EOE.

INTERNISTS, Board Certified or Eligible, needed for hospital satellite. Excellent opportunity to begin private practice with financial support from hospital. Some teaching responsibilities in accredited internal medicine residency program. Candidates who have recently completed a residency program in internal medicine preferred. Send resume to: Richard A. Emrich, Asst. to Chief Executive Officer, Edgewater Hospital, 5700 N. Ashland Ave., Chicago, Ill. 60660.

SITUATIONS WANTED

YOUNG E.N.T. SPECIALIST desires relocation to North or Northwest Suburban Chicago area, full or part-time. Contact Box No. 1010, Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago 60603.

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GRIDLEY, ILLINOIS: Long established practice for sale, rent or lease—completely furnished. Terms negotiable. Excellent schools, recreation, churches, and hospitals. Contact: J. Wesley Helm, M.D. Gridley, Illinois 61744. Telephone (309) 747-2083; 747-2185; 747-2479.

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OPHTHALMOLOGY OFFICE for rent on part-time basis. Downtown Chicago, new equipment, recently decorated, answering service. Must have own patients and own secretary. Please call 493-7040; 280-9057.

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MISCELLANEOUS

OCTOBER 2-4, 1981: Midwest Forum on Allergy, Stouffer's Inn, Cleveland, Ohio. Co-sponsored by the Cleveland and Ohio Allergy Societies. Approved 14 credit hours Category I of AMA-PRA. Info: Joseph Kelley, M.D., Cleveland Clinic, 9500 Euclid Ave., Cleveland, Ohio 44106, regarding scientific meeting and hotel reservations.

SNOWMASS/VAIL "MEP" SKI Seminar on management enrichment for the health professional. Continuing education time and money management seminars in Colorado 1981/82 ski season. Expenses deductible for doctor and spouse. Contact: M.E.P., An Education Corporation, 906 Cooper, Glenwood Springs, Colorado 81601; or call 1-800-525-3402.

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INTERESTED IN FINDING a certified physician assistant for your busy practice? A *free* placement service is offered through: Illinois Academy of Physicians Assistants, 55 E. Monroe - Suite 3510, Chicago, Illinois 60603; 312-263-7150.

EKG

(Continued from page 87)

Answers: 1. E 2. E

All of the answers in question one are true. The diagnosis of atrial fibrillation is difficult on this ECG strip. No P waves are seen and cycles following the premature ventricular beats are irregular. Premature ventricular beats occur with different QRS morphologies and different coupling intervals on an every other beat basis, *i.e.*, bigeminy. The first, third, fifth, seventh, ninth, and eleventh beats in line one are conducted beats. Line three shows the development of ventricular flutter and fibrillation.

This is a rare ECG tracing because it allows for evaluation of electrical events leading to the cardiac arrest. In this instance the entire ECG recording showed frequent premature ventricular beats that were multifocal and occurred in bigeminy and occasionally in couplets or pairs. Finally, the fifth ventricular beat in line three seems to strike on the T wave of the fourth ventricular beat. Ventricular flutter develops and rapidly deteriorates to ventricular fibrillation. Although both ventricular flutter and fibrillation are life threatening, ventricular flutter is diagnosed when the QRS morphology cannot be separated from the ST-T wave pattern. Here, this started with an R on T phenomenon. Our patient had severe heart disease which was presumed to be coronary artery disease. It was manifested by chest pressure at one point, cardiomegaly, complete left bundle branch block, and congestive heart failure. However, it was the ventricular ectopic activity that predicted his high risk of sudden death. Cardiopulmonary resuscitation was not successful. ◀

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IMJ Attention

ILLINOIS GENERAL ASSEMBLY ADJOURNS — The Illinois legislature adjourned July 2, and is not scheduled to reconvene before October 1, 1981. A number of bills pertinent to medicine now await signature by the Governor. Several others have died or will be acted upon in the next session.

HB1029 and HB1365, both supported by ISMS, have passed both chambers and await action by the Governor. As discussed in earlier issues of *IMJ Attention*, HB1029 would amend the Civil Practice act regarding the *res ipsa loquitur* doctrine in medical and dental malpractice cases. HB1365 would reinforce confidentiality protections for hospital peer review committees.

SB702, which would have allowed optometrists to administer diagnostic drugs, was defeated in the House Registration and Regulation Committee. Attempts to revive the bill were not successful, but are expected to recur this fall, or early in 1982.

HB1030, which makes positive changes relating to the Illinois Medical Examining Committee, was passed and awaits gubernatorial signature. The bill would transfer authorization for the Medical Examining Committee from the Civil Administrative Code to the Medical Practice Act; allow for a full time teacher of professional rank in one of the clinical departments at the UI or SIU schools of medicine as Committee member; provide that Committee members receive compensation equal to that of members of the Medical Disciplinary Board and permit IDPH to charge reasonable fees for lab services. (The last provision was an amendment proposed by IDPH; the Department can no longer provide lab services free of charge.) The Medical Examining Committee functions under the Illinois Department of Registration and Education. It is a seven member Committee responsible for review of physician candidates seeking licensure, implementation of rules under the Medical Practice Act and other medical matters other than discipline.

PUBLIC AID LEGISLATION — The Illinois Department of Public Aid budget passed by the Assembly provides $135 million for physician services over the next fiscal year; a $19 million increase over the amount allocated in last year's budget. Major cuts were made in the IDPA budget, but ISMS successfully defeated efforts to drastically reduce the physician line item.

HB811, limiting hospital reimbursement, was passed. Provisions directly affecting physicians were essentially those cost-saving proposals IDPA may currently implement under federal authority. These include the following, effective through June 30, 1982: reimbursement based upon the lesser of (a) 14% reduction in IDPA recipient in-hospital patient days or (b) an 8% cap on increased hospital per diem rates; establishment of IDPA "reasonable dollar limits for selected inpatient hospital services;" requirement that selected procedures be done on an outpatient or ambulatory basis when medically appropriate and limitation to one preoperative day for surgery or diagnostic testing, unless otherwise medically appropriate.

Enabling legislation for copayments also included in this bill limited physician copayments to a $1 maximum. IDPA has agreed to negotiate with ISMS prior to final rules to implement "copay" provisions for physicians, which also must be approved by a legislative committee.

MALPRACTICE UPDATE — Figures released through the *Cook Country Jury Verdict Reporter* show that 324 health related professional negligence suits were filed in Cook County during the second quarter of 1981, a 15% increase over the same quarter in 1980. Individual physicians were named in 199 of these lawsuits.

BLOOD LIABILITY REPEALER APPROVED — Another positive legislative note is passage and signature of HB223, which provides permanent waiver from liability for furnishing human blood and blood derivatives. That bill extends indefinitely the life of 1971 legislation exempting hospitals, physicians and blood banks from liability when transfusing blood or transplanting organs.

SUPPORT NEEDED FOR HB1155 — A bill to reduce barriers for a successful physician countersuit, HB1155, was defeated in the Senate Judiciary I Committee. The ISMS bill would have allowed a wrongfully sued individual to more easily bring legal action against the party who initiated the suit. A concentrated effort to pass HB1155 is planned for next Spring.

MEDICAL STAFF LEADERSHIP will be the subject of a Southern Medical Association seminar scheduled for October 1-2 at Lake of the Ozarks, Missouri. Participants will be eligible to receive AMA Category 1 credit and eleven elective hours from the American Association of Family Physicians. "Challenges of the Eighties," is intended for physicians about to assume leadership positions within a hospital. Seminars will discuss malpractice liability, quality care concerns, JCAH requirements, organizational behavior and cost containment issues. Further information may be obtained by writing Jeanette Stone, Registrar, PO Box 2446, 2601 Highland Avenue, Birmingham, Alabama 35201.

CHEMICAL DEPENDENCY will be the subject of a one day conference on October 2, at the Holiday Inn City Center in Chicago. Sponsored by the Chemical Dependence Program of Northwestern Memorial Hospital, the physician's workshop will include presentations on pathophysiology of alcohol and other sedative-hypnotics, prescription drug abuse and the impaired physician. Fee for attendance is $75, and further information may be obtained through Kenneth Tortoriello, Ph.D., Chemical Dependence Program, Northwestern Memorial Hospital, 320 E. Huron St., Chicago IL 60611; (312) 649-8713.

MMIS IMPLEMENTATION — The July issue of *IMJ* included a special section detailing physician responsibility under the newly implemented Medicaid Management Information System in Illinois. The Illinois Department of Public Aid has initiated MMIS in St. Clair and Cook Counties. The system will be activated in the balance of Illinois on September 15.

Physicians participating in the Medicaid program should receive a packet of materials to enable their enrollment in MMIS. The packet should include a Physician Enrollment Application, schedule of local information seminars and other materials. Physicians who have not yet received the packet of materials should contact IDPA at 800-252-8937, or write the IDPA Provider Participation Unit at PO Box 4034, Springfield 62708. Completion of the MMIS enrollment materials is required for continued participation in the Medicaid program.

JAIL HEALTH PROGRAM UPDATE — The McHenry County Jail, Woodstock, has been granted two-year accreditation for its health care system under the ISMS-administered Illinois Jail Health Project. Champaign County Jail received similar approval in April. Accreditation is achieved upon recommendation by an ISMS technical advisory committee and approval by the AMA.

In a related note, the AMA will sponsor a fifth national conference on Medical Care and Health Services in Correctional Institutions at the Chicago Marriott Hotel, October 30-31. Co-sponsored by the American Correctional Health Services Association, the conference offers workshops in drug offender treatment, health care needs of juveniles, health problems of incarcerated women, risk management and lawsuits and improving staff morale and performance.

Further information may be obtained by contacting the AMA Department of Correctional Activities, 535 N. Dearborn St., Chicago IL 60610.

Blue Cross® Blue Shield®
REPORT
FOR Illinois Physicians

ILLINOIS BLUE CROSS AND BLUE SHIELD PLAN TO FUND HEALTH COST CONTAINMENT PROGRAMS

The Illinois Blue Cross and Blue Shield Plan has announced the establishment of a $1 million funding program to encourage development of innovative health care cost containment programs in the state.

S. Martin Hickman, president of the Illinois Plan, said the program, to be initiated as a pilot for a 24-month period, will be supported through two approaches — grants and loans. Special emphasis will be placed on programs designed to impact on the cost of providing health care services.

Hickman said "the total funding package will be split evenly between projects in the Chicago metropolitan area and Downstate. Final approval of both grants and loans will be made upon recommendations from the Project Review Committees for the two areas.".

He said institutions and professional health care providers will be eligible for loans "for virtually any purpose that will lead to a significant reduction in health care costs," such as the completion of studies or the implementation of new programs that will improve productivity. Loans will be made on an interest-free basis for periods up to three of four years, with repayment related to the time during which cost savings occur.

Hickman said grant applications will be considered from professional and institutional organizations, community groups and multi-institutional consortia.

"The grants are intended to support studies covering such areas as institutional merger opportunities, consolidation of facilities and services, shared services programs and other programs that show promise of containing health care costs," Hickman noted.

"The many cost containment programs initiated by Blue Cross and Blue Shield and other members of the Voluntary Effort have had some braking effect on health care costs, but more needs to be done. We hope that this fund will spur new ideas and new approaches that will add up to major cost containment breakthroughs," Hickman said.

He termed the $1 million fund "seed money that could produce a savings of multi-millions in health care costs."

The Blue Cross and Blue Shield Board of Directors will evaluate results of the program in 1983 for possible extension.

Members of the Project Review Committees will represent Blue Cross and Blue Shield, Illinois corporations, the medical profession, hospitals and government.

Members of the Chicago area committee are: Juliann S. Bluitt, D.D.S., Associate Dean of Auxiliary and Community Programs, Northwestern University Dental School and a Blue Cross and Blue Shield board member who will serve as Chairman; James D. Mortimer, president of the Midwest Business Group on Health and Andrea R. Rozran, president of Diversified Health Resources, Inc., Blue Cross and Blue Shield corporate members; John F. Imrie, Jr., director of Foster G. McGaw Hospital, Loyola University Medical Center, a hospital representative; Robert C. Stepto, M.D., professor of the Department of OB/Gynecology at Chicago Lying-In Hospital, medical representative and a Blue Cross and Blue Shield corporate member; Philip R. Davis, executive director of the City of Chicago Health Systems Agency, government representative; and Charles R. Goulet, executive vice president of the Illinois Plan.

Downstate committee members are: Donald N. Swaar, president of the Illinois Health Improvement Association and a Blue Cross and Blue Shield board member who will serve as chairman; Ray A. Neumann, senior vice president of First Federal Savings and Loan Association of Peoria and Karl Jacobs, president of Rock Valley College, Rockford, Blue Cross and Blue Shield corporate members; Jack M. Cook, president of Memorial Medical Center of Springfield, hospital representative; Jerry M. Ingalls, M.D., of the Medical Center Clinic, Paris, Illinois, medical representative and a Blue Cross and Blue Shield corporate member; William L. Kempiners, director of the Illinois Department of Public Health, government representative; and C. Jonathan Shattuck, vice president of Hospital and Provider Affairs for the Illinois Plan.

EMERGENCY BENEFITS EXPLAINED

(Please Note: The Chicago-based Blue Cross and Blue Shield Plan has developed a booklet for its membership explaining the proper use of emergency benefits provided by the Plan. Because the information contained in the booklet may be of interest to you, we are including excerpts from it in the following report.)

"Blue Cross and Blue Shield benefits cover the treatment of injuries resulting from accidents, attacks on your person, slips or falls—in brief, any injury which requires prompt attention. These include...fractures of all types, sprains or strains, burns, cuts and any injury requiring immediate surgery.

Follow-ups not covered

"Benefits include Out-Patient or Emergency Department care and the services of the attending physician, provided treatment is received within 72 hours of the accident or injury. This applies only to the first treatment. Follow-up out-patient visits are not covered under emergency benefits. In those cases where a hospital stay is necessary, you will be covered for all charges eligible under your particular Blue Cross and Blue Shield program.

"Since accidents can occur anywhere at any time, it's good to know that your Blue Cross and Blue Shield membership card quickly identifies you to hospitals and doctors throughout the country. Always carry it with you when you travel.

"Benefits are provided for medical emergencies when symptoms are severe enough to endanger life or bodily functions unless the patient receives prompt treatment. The following conditions are examples of true medical emergencies...sudden chest and arm pains severe enough to indicate a possible heart attack, severe bleeding of any kind, including vomiting of blood, sudden inability to move arms or legs, severe allergic reactions and attacks of dizziness severe enough to cause staggering.

First treatment eligible

"In cases such as those listed above... benefits are provided for the first treatment whether received in the Emergency Department or Out-Patient Department of a hospital or clinic, or in the doctor's office. Treatment should be received immediately for symptoms severe enough to require emergency care. As is the case with injuries, only the first treatment is eligible for emergency benefits. If a hospital stay should be necessary after your condition is diagnosed, you will, of course, be covered for all services eligible under your particular Blue Cross and Blue Shield program.

"When you use emergency facilities simply for convenience—because you can't get a doctor's appointment or because the Emergency Department is such a handy place to have your blood pressure checked—be prepared to pay for the service yourself. On the other hand, you can count on Blue Cross and Blue Shield benefits to take care of true emergencies wherever treatment is received—in a hospital facility, an approved surgical center or clinic, or in the doctor's office.

"Note: Patients having Major Medical coverage in addition to their basic Blue Cross and Blue Shield program may receive benefits for follow-up care after the Major Medical deductible has been met."

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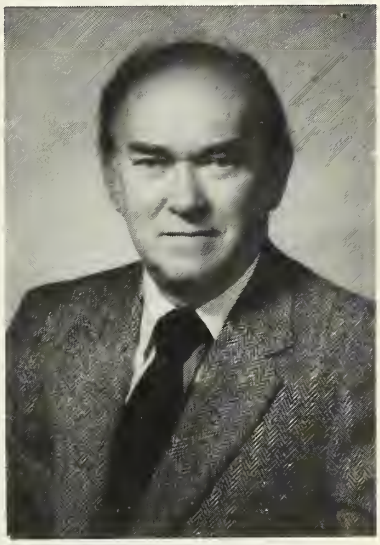
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President's Page

The High Cost of Quality



Those that study and then critique medical care on the basis of cost or necessity often ignore a most basic and critical concept—that of quality.

Cost evaluations usually are offered in terms of quantifiable values, such as comparisons of similar surgical procedures in different areas. The truth is, actually quantifiable areas in medical care are rare. Most of the care rendered improves the quality of life, but is expensive and most difficult to measure.

Many of our efforts are not directed toward life or death crises, but are intended to improve sight, decrease pain, or restore or maintain function. Society—knowing that this capability exists—expects to receive these services. Medically, it usually is a great deal more expensive to keep someone comfortable and reasonably functional in the last five years of his or her life than it was in all of the person's preceding years.

Certainly, as physicians, we should be accountable: we should decrease waste and increase our efficiency. However, we should not apologize for high cost technology and the ability that is available and expected by our patients and their families.

The decision to reduce or alter quality is a societal responsibility. Unless society decides differently, our posture should be to provide what is available and not to apologize for our ability to do so. ◀

Fred Z. White, M.D., President

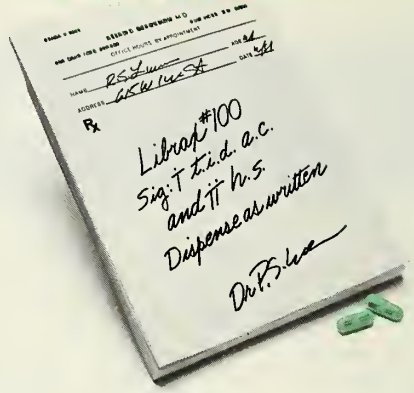
Clinics for Crippled Children Listed for October

Forty clinics for Illinois' physically handicapped children have been scheduled for October by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 27 general clinics, 10 cardiac clinics, one for children with neurological problems and two for myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

1 Sterling—Community General Hospital
1 Anna—Union County Hospital
1 Lake County Cardiac—Victory Mem. Hosp.
2 Division Cardiac—U. of I. at the Medical Center
5 Peoria Myelodysplasia—St. Francis Medical Center
5 Belleville—Belleville Memorial Hospital
6 Quincy—Blessing Hospital
6 Maryville—Oliver C. Anderson Hospital
6 Danville—Lake View Hospital
6 Park Ridge Cardiac—AM—Lutheran General Hospital
6 Park Ridge General—PM—Luthern General Hospital
6 Wheaton General—Marianjoy Rehab. Hosp.
7 Hinsdale—Hinsdale Sanitarium
8 Aurora Cardiac—Mercy Center for Health Care Services
8 Kankakee General—St. Mary's Hospital
12 Peoria Cardiac—St. Francis Med. Center
13 East St. Louis—Community Hospital
14 Mt. Vernon—Good Samaritan Hospital
14 Champaign-Urbana—McKinley Health Service Center
14 Chicago Heights General—St. James Hosp.
14 Joliet—St. Joseph's Hospital
14 Elgin MM—Sherman Hospital
15 Rockford—St. Anthony Hospital
15 Springfield—St. John's Hospital
15 Bloomington—Mennonite Hospital
15 Elmhurst Cardiac—Memorial Hospital of DuPage County
16 Kankakee Cardiac—St. Mary's Hospital
19 Chicago Heights Cardiac—St. James Hosp.
19 Maywood—(Orth/Ped)—Loyola Med. Center
20 Rock Island General—Moline Public Hosp.
20 Decatur—Decatur Memorial Hospital
21 Springfield Ped-Neuro—St. John's Hosp.
21 Aurora General—Mercy Center for Health Care Services
21 Chicago Heights General—St. James Hosp.
22 Metropolis—Massac Memorial Hospital
23 Evanston—St. Francis Hospital
26 Peoria Cardiac—St. Francis Med. Center
26 Chicago Heights Cardiac—St. James Hosp.
26 Maywood—(Orth)—Loyola Medical Center
27 Peoria—St. Francis Medical Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

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Final classification of the less-than-effective indications requires further investigation.

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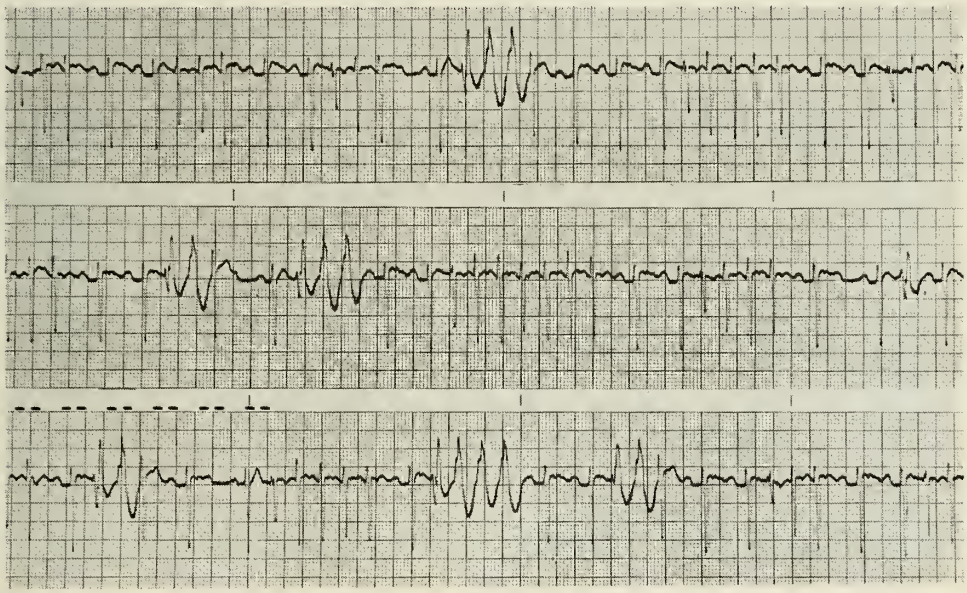
Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

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EKG of the Month

This is a seventy-five year old patient who had a history of chronic obstructive pulmonary disease. He was brought to the emergency room unresponsive and cyanotic. His family gave the history of progressive dyspnea over the several hours prior to his admission. The patient was afebrile with a rapid respiratory rate. Examination of the lungs showed diffuse scattered rales and bronchi. The cardiac exam was significant for an irregular rate of 150 to 160 beats per minute. Pertinent blood work included a hematocrit of 48%, pH 7.20, pCO_2 60, pO_2 50, and CPK enzyme normal. A chest X-ray showed increased density throughout both lungs with prominent vascular markings suggestive of pulmonary edema. A lead V_1 rhythm strip was obtained and is shown.



Questions:

1. The lead V_1 rhythm strip shows:
A. Sinus tachycardia.
B. Short runs of ventricular tachycardia.
C. Short runs of supraventricular tachycardia with aberrant intraventricular conduction.
D. Paroxysmal atrial fibrillation.
E. All of the above.

2. The following statement(s) is/are true:
A. The clinical diagnosis is respiratory failure.
B. Treatment should include oxygen therapy by nasal cannula at whatever flow rates raise the pO_2 to normal.
C. Endotracheal intubation and intermittent positive pressure ventilation should be used.
D. Diuretic therapy with furosemide or ethacrynic acid could be useful.
E. All of the above.

(Continued on page 196)

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Guest Editorial

Sleep Deprivation In Graduate Medical Education

By Ronald M. Davis/Chicago

You expect a rigorous time, you welcome it, you know it is the only way to learn.
—Joseph English, M.D.[1]

Graduate medical education training programs often include work schedules that approach or exceed 100 hours per week. Such work schedules are familiar to all physicians. In fact, most recall the arduous days they themselves had spent as house officers with pride and happiness.[2] Yet if one questions the interns and residents, one obtains an entirely different perspective.

Before taking a closer look at the effects of sleep deprivation on house officers, how can we account for this disparity of opinion? McManus, *et al.*, have a ready explanation: "Cognitive dissonance theory predicts that when one has been through an unpleasant experience which is voluntary the very unpleasantness of it makes one more likely, retrospectively, to justify that experience and advocate it for others."[3]

The Sleepy Intern

Friedman, *et al.*,[4] reviewed studies on the psychological symptoms that accompany total or partial sleep loss in the general population. They also interviewed 14 interns in a New York City hospital in both sleep-deprived and rested states. These interns were on an alternate-night on-call work schedule. Since they elected to work routinely two nights consecutively in order to be off every other weekend, 60-hour on-call periods were common.

The symptoms reported by subjects when sleep-deprived but not when rested fell into seven categories. Because of their alarming nature, the examples cited by Friedman, *et al.*, are presented below. The numbers in brackets represent the number of subjects from the total sample of 14 who reported the particular symptom.

Difficulties thinking [12]—When I'm tired, even though my mind is active, I can't concentrate. I can't put things together in my mind so I don't even try. If a patient is really sick, I can pull myself together but I can't write down what I've done in the chart. What I write is a reflection of a fragmented thought process. Writing in charts is important to me. I write for attendings, residents, and students. It gets me scared when this happens because it means that I am losing control of my ability to think.

Depression [10]—I sometimes get funny feelings on my skin when I am tired. I don't know if it's the perspiration and the filth that comes from being up a lot, or it is basically the feeling that I am not clean. My home life suffers and I miss my wife greatly. I feel ashamed that I get tired

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and can't live up to the tradition of the iron men. A patient died last night. I was not successful treating him. He was a little old nice guy. I feel I let him down. It happened at 1:00 a.m. I thought about whether my fatigue affected my performance in this case. After much soul searching, I decided not.

Irritability [9]—If you're on two nights in a row, you want to do as little as possible. You give bad care. I am irritated all the time then; I can only think of one thing at a time. I can't react to complexity. I give bad care to my patients, unfortunately. When I'm tired, I don't give a damn.

Referential feelings with extreme sensitivity to criticism [6]—I feel almost like everyone is watching me. If I slip up, everyone will watch and see. I'm hypersensitive to criticism when I'm tired. I feel I'm being watched more carefully.

Depersonalization—derealization [6]—I feel as if I'm not really there. I am discontinuous. My writing is discontinuous. I feel discontinuous.

Inappropriate affect usually associated with black humor [5]—I laugh at things that aren't really funny. I'm giggly when I'm tired. For instance last night a patient came in comatose. Another intern asked the patient: "Do you have any parakeets at home?" I found that enormously funny and I laughed and laughed. I'm punchy when I'm tired. Things don't seem so funny to me when I am rested. Another example of my sense of humor when I am fatigued would be: An intern gets a patient with congestive heart failure and pulmonary edema. He makes a wise comment like, "Give her some vitamins and send her home." That makes me crack up. I would not find such a remark funny when I am rested.

Recent memory deficit [5]—I would forget what I just said so my next sentence would make no sense. I also stop sentences midway a lot because I forget what I wanted to say.

British Corroboration

The New York City interns are by no means unique. A British survey of 64 "housemen" yielded similar findings.[3] Ninety-four percent considered that lack of sleep had commonly (25) or occasionally (35) affected their efficiency of working. Eighty-one percent felt that lack of sleep had commonly (18) or occasionally (34) affected their relationship with patients.

Some of their individual remarks are even more disturbing. One house officer complained of having become "a tired, bad-tempered, psychological wreck, lying back with relief on hearing at 3 a.m. that a patient had died in the ambulance on the way in." Another explained that after lengthy periods without sleep, the house officer "was often so tired that he was a positive danger on the wards—often a danger because of sheer apathy."

To grasp the clinical implications of all this testimony requires little imagination. It is not at all surprising to learn, for instance, that sleep-deprived interns are significantly less able than rested ones to recognize arrhythmias on the electrocardiogram.[5]

We should make no mistake about it—*the sleep-deprived house officer is an impaired physician.* Close inspection reveals remarkable similarities between him and the otherwise impaired physician. Both suffer from excessive stress, psychological problems, strained relationships with spouse or loved ones, and diminished efficiency on the job. Yet the case of the latter receives increasing attention while the demise of the former is largely ignored. We should recall the admonition, "Physician, heal thyself." The sleepy intern presents a poor role model to the patient whom he attempts to educate on healthy lifestyles.

Reasons

There are at least four identifiable reasons why such a situation exists. At best, they are less than satisfactory; at worst, they defy logic or contradict medical ideals.

Friedman, *et al.*, offer two explanations. The inevitable psychoanalytical theory, which might alternatively be called the "masochism theory," is that: ". . . the sleep deprived intern acts out an unconscious wish widely held by physicians to possess abilities and powers that transcend what is ordinarily thought of as human The search for omnipotence may be understood as the acting out by particular members of the physician group of a defense against anxiety generated daily by the often frustrating struggle against disease and death."[4]

Another physician seems to offer the same argument, in less abstract terms, on the basis of a competitive spirit which makes it difficult for the house officer to quit when he knows he should. "Even if a replacement is available, most physicians set terribly high standards for themselves. Reluctant to damage the superhuman doctor myth, they are determined to do as well as the 'giants' who went before them."[1]

Friedman, *et al.*, also put forth the idea, which has recently received attention elsewhere,[6] that the internship functions as an initiation rite into an elite society. Many physicians undoubtedly defend interns' heavy work schedules by such reasoning. "I went through it, and it made a better doctor out of me," the thinking goes. "Besides, why should today's interns have it any easier than I did?"[1] So while we condemn the hazing of col-

lege fraternities that may injure, maim or even kill a young "pledge,"[7] we condone the initiation rites of the fraternity of medicine, whose injurious effects are often as severe and certainly more common.

A third explanation is that the long hours of work are necessary to develop the skills of a competent physician. The best refutation of this is the premise that "skill is gained on a law of diminishing returns and would hardly be affected by reducing hours working at night."[3] As one resident explains, "Fourteen straight hours on emergency room duty can reduce the most competent and dedicated intern to a mechanical robot and render the most valuable experience meaningless."[1] This is to say nothing of the fact that long work schedules leave little time to read and scant energy to stay awake during conferences. One final point worth mentioning is that the apathy and disillusionment with medicine often associated with sleep deprivation may put a damper on the young physician's supposedly enthusiastic quest for knowledge.

The last explanation is that house officers' lengthy work schedules are necessary to serve the manpower needs of a hospital's patient population. Any truth to this reason would confirm the claim that "interns are used as cheap labor."[1] Certainly, many of the nocturnal duties of the house officer could be alleviated by hiring extra ancillary personnel or more physicians. However, the financial obstacles to this have so far overcome the still relatively weak collective bargaining strength of resident physicians. As a result, the greatest work burden remains on the shoulders of the low man on the totem pole. And the future seems even bleaker. The Graduate Medical Education National Advisory Committee (GMENAC) recently predicted a doctor glut by 1990 and recommended a reduction in medical school enrollments.[8] The implementation of this recommendation would ultimately deplete the intern pool and—all other things being equal—increase the burden on each individual intern.

Remedies

Few solutions have thus far been proposed to address this problem. After all, the issue has been the focus of only a half dozen or so articles in the medical literature.

Elwood and Barr[9] offered a proposal that has received little if any attention. They showed that simply rearranging work schedules could reduce by 80% the time on call in excess of 24 hours' consecutive duty, without changing the services or administration of the unit in other ways.

Hospital administrators should more carefully consider devoting some of their scarce funds to hiring extra ancillary personnel so as to minimize house officers' "scut" work. They should hire more physicians if possible to accommodate heavy patient loads.

Program directors and attending physicians should be more sensitive and responsive to house officers' needs. As one intern remarked, "The biggest drawback of the houseyear is the almost callous disregard by the senior medical staff, and to a lesser extent by nursing staff, of the need of a houseman for sleep."[3]

A national survey of graduate medical education training programs should be undertaken to measure the scope of the problem. How many programs, for instance, have alternate-night on-call schedules? If such a survey reveals widespread abuse of residents' need for sleep, standards for on-call duty could be set by the Accreditation Council for Graduate Medical Education (ACGME), the agency responsible for accrediting residency programs.

Standards for residency program accreditation are detailed in the ACGME document, ESSENTIALS FOR ACCREDITED RESIDENCIES. The Essentials include "General Requirements" for all residencies and "Special Requirements" for each particular specialty. The "General Requirements" (which were recently revised) do not include guidelines for on-call schedules. They merely urge that "each resident be offered for acceptance a written agreement encompassing . . . the usual call schedule." The "Special Requirements for Residency Training in Internal Medicine," however, do recommend on-call duty "every third or fourth night." The possibility of the ACGME establishing *general* standards for on-call schedules, either as recommendations or requirements, should receive consideration.

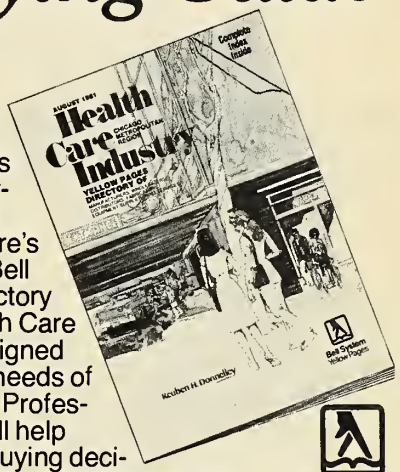
Finally, on-call schedules should be published in the American Medical Association's DIRECTORY OF RESIDENCY TRAINING PROGRAMS. Although the preface to the current directory states that its publication on an annual basis prevents the inclusion of "such variable information as on-call time," this possibility should be reexamined. After all, the Directory includes such "variable information" as number of necropsies, annual outpatient visits, and total *in vivo* procedures. Besides, a program with an alternate-night on-call schedule one year is reasonably likely to have an alternate-night on-call schedule the following year. With easier access to this information, the degree of interest expressed in the less humane programs may diminish. Especially (and perhaps only) then will program directors be inclined to make their programs less punishing.

As McManus, *et al.*,[3] concluded, "The houseyear is, at best, very unpleasant for a large number of doctors, and needs serious reconsideration." ◀

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Illinois Society, American Association of Medical Assistants

Staying Abreast Of Fast Advances

By Mari Lakadat, McLean County Chapter

A *Wall Street Journal* article profiles a general practitioner's system for staying abreast of medical advances. Almost daily progress in medicine can mean time consuming efforts just to become familiar with all the new information.

In our consumer oriented society, mandatory recertification of specialists, as well as general practitioners, seems inevitable. The close scrutiny given physicians today extends to their medical personnel—and should be welcomed. What better way to prove one's capabilities than ensuring that medical care provision will bear up under close scrutiny.

Recognizing this growing trend toward certification, the American Association of Medical Assistants, several years ago, began certification procedures for members and nonmembers. By certifying a medical assistant's knowledge, recognition is given for on-the-job training, possibly coupled with a formal course of study in a school of medical assisting.

Recertification of the medical assistant requires continued attendance at educational workshops, seminars and travel courses. As physicians all over the country plan ways in which extra hours can be allotted to their continued education, thought should also be given to the continued education of their employees, an extension of their health care team.

A medical assistant need not require recertification from state to state, but recognition is given for meeting certain basic educational criteria recognized nationally.

Physicians who are today evaluating their continuing education goals, should also be aware of the goals of their medical assistants, providing a conducive atmosphere for educational pursuits as well as good patient care. A medical practice will continue, it is said, as long as a physician provides congenial care. However, today's patients also want assurance that the physician not only understands their particular medical problem but is aware of all alternative treatments, either time-proven methods or new medical advances. An up-to-date and knowledgeable medical assistant is a boon to a busy physician.

Continuing education for the physician includes medical meetings, seminars, workshops and periodicals. These means for continuing education are also available to medical assistants through the American Association of Medical Assistants, which cites its primary purpose as education.

If you are keeping in step with medical advances, Doctor, is your medical assistant keeping in step with you?

For further information regarding A.A.M.A., please contact Mary Lu Ostrowski, CMA, President, Illinois Society, 1704 East Jackson, Bloomington, Illinois 61701, or Mari Lakadat, Chairman, Public Relations Committee, c/o William Sawyer, M.D., 107 E. Chestnut, Bloomington, Illinois 61701. ◀

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Conditions Which Affect Interpretation Of Thyroid Function Tests

By Richard Ravel, M.D./Quincy

This review outlines the current status of laboratory tests for hyperthyroidism and hypothyroidism. Various conditions are pointed out which may produce falsely abnormal and also falsely normal test results. These conditions create more diagnostic problems than most physicians realize, especially in hospitalized patients.

It has become increasingly evident in recent years that many more problems beset interpretation of thyroid function tests than most physicians realize.[1,2] This review attempts to call attention to some of these problems. Only hyperthyroidism and hypothyroidism will be included. The basic laboratory tests currently used for diagnosis of thyroid disease will be discussed, in order to delineate both the contributions and the pitfalls of each toward diagnosis of hyperthyroidism and hypothyroidism.

In order to clarify certain points, it might be desirable to briefly review thyroid hormone metabolism.[3,4]

Iodine is extracted from the blood by the thyroid and one iodine atom is attached to a tyrosine molecule to form monoiodotyrosine. One additional iodine atom is then attached to form diiodotyrosine. Two diiodotyrosine molecules are combined to form tetraiodothyronine (thyroxine, T4), or one monoiodotyrosine molecule can be combined with one diiodotyrosine molecule to form triiodothyronine (T3). Normally, the great majority of thyroid hormone secretion is T4 with only approximately 7% being T3. In the blood, over 99% of both T4 and T3 are bound to serum proteins. About 80-85% of T4 attaches to thyroxine-binding globulin (TBG), an alpha-1 globulin; about 10-15% to pre-albumin; and about 5% to albumin. About 70% of T3 is bound to TBG and most of the remainder to albumin. Protein-bound hormone is metabolically inactive, as though it were located in a storage warehouse. The unbound ("free") T4 and T3 are metabolically active in body cells. Within body cells, par-

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ticularly the liver, some free T4 is converted into T3, representing about 80% of daily T3 production. T4 is also converted into a compound known as reverse T3. Reverse T3 is not biologically active. Finally, there is a system of control over thyroid hormone production and secretion based on thyrotropin-releasing hormone (TRH, thyroliberin, protirelin) from the hypothalamus, which stimulates the pituitary to secrete thyroid-stimulating hormone (TSH, thyrotropin). TSH regulates normal thyroid production and release of the thyroid hormones T4 and T3. In turn, decreased serum levels of free T4 and T3 stimulate TRH production, while increased levels of free T4 and T3 directly inhibit pituitary secretion of TSH as well as inhibit TRH production.

Thyroid Function Tests in Hyperthyroidism

According to standard concepts of thyroid disease, there are two basic types of hyperthyroidism: diffuse thyroid gland overactivity, also called Graves' Disease; and focal nodular hyperactivity, also called toxic nodular or Plummer's Disease. Hyperthyroidism of either etiology is usually subdivided into two types, depending on thyroid hormone measurement. These are traditional or standard variety, in which both serum thyroxine (T4) and serum triiodothyronine (T3) are elevated; and "T3 Toxicosis", in which serum T4 values are within normal population range and serum T3 alone is elevated.[3] Evidence has been accumulated that classification of hyperthyroidism into T4/T3 and T3 types alone is no longer valid.[5,6] Also, laboratory diagnosis is less straightforward than previously believed. A review of the standard diagnostic procedures for thyrotoxicosis will help provide a background for consideration of problems in laboratory test interpretation.

One of the oldest laboratory tests of thyroid function is the *radioactive iodine uptake* (RAIU).[7-10] This is an indirect estimate of thyroid hormone production based on the need of the thyroid for iodine to make thyroid hormone, which in turn depends on the rate of thyroid hormone synthesis. Unfortunately, this test has many drawbacks, including seven major problems discussed below:

(1) 50-70% (literature range 20-80%)[7,8] of patients with hyperthyroidism due to toxic nodules do not have elevated RAIU.

(2) Excess iodine competes with radioactive iodine for thyroid uptake, thereby preventing uptake of radioactive iodine and falsely decreasing test results. Iodine excess in the blood is due to iodine in certain medicines (inorganic iodide) or in X-ray contrast media (organic iodine).

(3) Normal values are uncertain due to increasing environmental and foodstuff iodine and inability of most nuclear medicine departments to obtain normal values for their own locality.[9]

(4) RAIU is falsely elevated in iodine deficiency and some persons with severe liver disease.[7]

(5) The standard 24-hour uptake requires two patient visits and two days.

(6) Occasional patients with hyperthyroidism have unusually fast synthesis and release (turnover) of T4 and T3. The RAIU measurement depends not only on RAI uptake but also on retention of the radioactive iodine (incorporated into hormone) within the gland until the amount of radioactivity within the gland is measured. By 24 hours a significant amount of newly-formed hormone may already be released, providing falsely lower thyroid radioactivity values compared to earlier (2-6 hour) uptake measurements.

(7) Poor separation of normals from hypothyroids.[8,9]

These difficulties have precluded use of the RAIU for screening purposes. However, the RAIU in conjunction with the thyroid scan has definite value in patients with laboratory evidence of hyperthyroidism:

(1) The scan can differentiate between diffuse and toxic nodular hyperthyroidism, entities which require different treatment.

(2) Occasional patients with chronic lymphocytic thyroiditis have symptoms of thyrotoxicosis.[11] Serum T4 and T3 are usually elevated. Both elevated and low 24-hour RAIU have been reported. Early (2-6 hour) uptake may be elevated more frequently than 24-hour uptake. Thyroid scan typically has a characteristic non-uniform appearance which can be helpful in suggesting the diagnosis.

(3) Facitious (self-medication) hyperthyroidism and subacute thyroiditis usually have a low RAIU in conjunction with elevated T4 (falsely low RAIU due to iodine intake must be excluded).[12,13]

T3 Uptake Tests

T3 uptake (T3U) does not measure T3, as its name might imply, but instead estimates the amount of non-occupied (unsaturated) thyroid hormone binding sites on serum proteins and has also been used as an indirect estimate of T4. Radioactive T3 placed into patient serum competes with a special hormone-binding resin or other binding material for binding sites on serum proteins. The number of T3 binding sites available on serum proteins depends primarily on the amount of T4 already bound, assuming normal quantities of protein, since T4 molecules greatly

Table 1

Certain Compounds Which Affect T4 and T3U (Compiled From Various Sources)

	T4	T3U
Oragrafin	Increase	Nane
Telapaque	Slight Increase	Nane
Other X-Ray Contrast Media	Nane	Nane
T4 Campaunds	Increase	Increase
T3	Decrease	Decrease
Estragens	Increase	Decrease
Halathane	Increase	?
Herain ar Methadane	Narmal/Increased‡	Narmal/Decreased
Heparin	Narmal/Increased*	Nane
Prapylthiauracil ar Methimazale (Tapazale)	Decrease	Decrease/Narmal
Barbiturates	Narmal/Mild	Narmal/Mild
(lang-term)	Decrease	Increase
Dilantin	Decrease	Nane**
Andragens	Decrease	Increase
Carticasteraids	Narmal/Decrease	Increase
Salicylates (large dases)	Decrease	Increase†
Perphenazine (Trilafan)	Occasianally Increased	Occasianally Decreased
Chlarpramazine (Tharazine)	Narmal/Decrease	Narmal/Decrease
Caumarin	Nane	Increase
Penicillin (large dases)	Nane	Narmal/Increase
Lithium Carbanate	Narmal/Decrease	Narmal/Decrease
Prapranalal (Indural)	Narmal††	Nane

‡ Usual effect/less frequent effect.
* Increased during 15-60 minute time periad after injectian.
** One repart indicates same elevatian.
† At least ane repart indicates na effect.
†† Disagreement whether T4 is unchanged ar slightly increased.

outnumber T3 molecules. Radioactive T3 not able to bind to protein is forced onto the resin. Therefore, the greater amount of T4 bound to protein, the fewer protein binding sites are available for radioactive T3 and the greater radioactive T3 uptake of the resin. T3U is not affected by iodine but is influenced by changes in the thyroxine-binding proteins. Other disadvantages are poor separation of normal from hypothyroid and interference by a considerable number of medications, the majority of which also affect serum T4 assay (Table 1). In addition, atrial fibrillation and severe acidosis sometimes falsely increase T3U.[14]

Total Serum T4

Total serum T4 can be measured directly by radioassay (or more recently, by enzyme-linked assay). Radioassay involves competition of patient hormone and radioactive hormone for a hormone binder. In T4 by radioimmunoassay (T4-RIA) the binder is anti-T4 antibody; in competitive binding or displacement methods (T4-CPB or T4D) the binder is T4-binding serum protein. After patient T4 and radioactive T4 have reacted with the T4 binder, the bound complex is separated from the free (unbound) hormone and the radioactivity in either the bound or free fraction is counted. The amount of patient T4 determines the amount of radioactive T4 allowed to attach to the binder. Over 99% of total serum T4 is protein-bound; the contribution of free T4 to the test result is negligible. Therefore, serum T4 by any of these methods essentially measures protein-bound T4 and will be affected by alterations in T4 binding proteins. These alterations may be congenital, drug-induced, or produced by non-thyroidal illness (Table 2).[15] As a rule of thumb, estrogens increase TBG while most other drugs decrease TBG or T4 binding to TBG.

Three methods are available to correct T4 assay for effects of thyro-binding protein alterations. The Free Thyroxine Index (FTI, FT4I, Clark & Horn Index, T-7, T-12) consists of the T4 result multiplied by the T3U result. This manipulation takes advantage of the fact that T3U and T4 values travel in opposite directions when TBG alterations are present, but they procede in the same direction when TBG is normal and the only variable is the amount of T4. For example, estrogen in birth-control medication or pregnancy elevates thyroxine-binding globulin (TBG) levels. Normally, TBG is about one-third saturated. If TBG is increased, the additional TBG also becomes one-third saturated. Thus, total T4 is increased (normal amount of T4 plus the extra T4 on the extra TBG). TBG binding sites are similarly increased by the additional TBG, leading to decreased T3U (additional radioactive T3 is bound to the additional TBG, with less T3 attracted to the resin). Therefore, if estrogens increase TBG, T4 is increased and T3U decreased; the high number multiplied by the low number produces a middle-range normal Index number.[15]

Several manufacturers have devised techniques for internally "correcting" T4 results for effects of TBG alterations. Depending on the manufacturers, these have been called "ETR," "Normalized T4," and other brand names.[16]

Another approach is to measure free T4 rather than total T4. The amount of protein-bound inactive T4 by itself has no direct influence on the serum level of metabolically active free hormone. The original Sterling technique involved separation of free from protein-bound T4 by a dialysis membrane. The procedure was complicated and was available only in a few reference laboratories. Recently, at least three manufacturers have in-

Table 2

Causes For Increased TBG

- Increased estrogens
 - Pregnoncy
 - Birth control pills
 - Estrogen theropy
 - Other medicotions
 - Perphenazine (Trilofon) (occasionolly)
 - Heroin ond Methodone (voriable degree)
- Severe liver diseose
 - Severe ocute hepatitis
 - Severe cirrhosis (occosionally)
- Congenital
- Acute Intermittent Porphyrio

troduced free T4 kits simple enough to be within the technical ability of most ordinary laboratories.[17]

Total Serum T3

Total serum T3 may be assayed by the same technique as T4-RIA. Total serum T3 (T3-RIA) is a specific direct measurement of T3 using anti-T3 antibody, and should not be confused with T3U, which is an estimate of serum protein unsaturated binding sites and also very indirectly estimates T4. Analogous to T4 procedures, serum T3 consists mostly of protein-bound T3. Therefore, serum T3 measurement is affected by alterations in thyro-binding proteins, although to a slightly lesser degree than serum T4.[3] One may obtain a free T3 index (FT3I) using T3-RIA and T3U values.[18]

The last two tests to be discussed involve manipulation of the pituitary-thyroid feedback system. The so-called *"T3 suppression"* test consists of 3-8 days of T3 administration.[19] Exogenous T3 (Cytomel) suppresses pituitary TSH secretion. In normal persons, decreased TSH is followed by sharply decreased serum T4 production. In hyperthyroidism, the thyroid produces T4/T3 without the usual regulation by TSH; therefore the thyroid is not suppressed by Cytomel and serum T4 or RAIU demonstrate little change ("positive" test result). This procedure has generally been considered reliable in confirming hyperthyroidism, although there are reports that 25% or more cases of non-toxic nodular goiter may fail to suppress.[19] The major drawback is that administration of T3 may be hazardous to elderly patients or those with cardiac disease.

More recently, synthetic TRH (Thypinone) has become available. Administration of TRH normally results in a marked rise in serum TSH levels. In hyperthyroidism, TSH production is suppressed (by direct effect of excess T4/T3 on the pituitary) and TSH assay after TRH fails to demonstrate the expected degree of TSH increase. The *TRH test* is currently considered the most reliable confirmatory procedure for hyperthyroidism, and is being used as the standard against which all other tests are compared for accuracy.[20] Unfortunately, about 5% false positive results *(e.g.,* failure to elevate TSH after TRH) have been reported in persons without demonstrable hyperthyroidism, so that a positive result is considered strongly suspicious but not conclusive for thyrotoxicosis. A normal result (normal degree of TSH elevation after TRH) is currently considered very reliable in excluding thyrotoxicosis. TRH response is reported to decrease nearly 50% in males (but not females) over age 60, although this has been disputed. Prolonged fasting (carbohydrate deprivation), aspirin, L-dopa and adrenocorticoid therapy depress TSH response to TRH. Finally, patients should discontinue dessicated thyroid or T4 therapy for at least 14 days or T3 therapy for at least 7 days before a TRH test.[21] Another drawback is $30-$40 cost for TRH and the need for 2 or 3 TSH assay specimens.

Laboratory Test Alterations

Since the diagnosis of thyrotoxicosis is usually based on laboratory results as well as clinical findings, one must consider what laboratory test alterations are produced in hyperthyroidism. Laboratory diagnosis ("Laboratory hyperthyroidism") is based on elevated values of serum T4 and T3, the two active thyroid hormones. Laboratory hyperthyroidism can be subdivided into 3 categories, depending on T4 and T3-RIA results: (1) standard T4/T3 Toxicosis (both T4 and T3-RIA elevated); (2) T3 Toxicosis (T3-RIA elevated, T4 not elevated) and (3) T4 Toxicosis (T4 elevated, T3-RIA not elevated).

Standard T4/T3 toxicosis comprises nearly 95% of hyperthyroidism. T3 toxicosis is estimated to occur in 3-5% of hyperthyroidism patients (literature range 2.4-30%).[3] RAIU and T3U are usually normal. There is some evidence that T3 toxicosis may be associated more often with Plummer's than with Graves' Disease,[22] although not all investigators agree. One report indicates that T3 toxicosis is more common in iodine-deficient areas (although some of these cases might have been pseudo T3 toxicosis with T4 decreased because of the iodine deficiency).[23] The incidence of T4 toxicosis is unknown. Until recently, the entity was rarely mentioned, or it was assumed to be less frequent than T3 toxicosis. In more recent articles on this subject, incidence ranged from 0-21% of hyperthyroid patients.[5,24,25] Several

investigators report that T4 toxicosis is more commonly found with iodine-induced hyperthyroidism (Jod-Basedow disease).[26] T4 toxicosis is also found more commonly in elderly persons,[5] but in some reports it is difficult to be certain that some cases were not pseudo T4 toxicosis with depressed T3-RIA due to concurrent severe illness. The true incidence is probably less than that of T3 toxicosis.

Each of the three categories of true laboratory thyrotoxicosis has a counterpart in which the apparent pattern does not reflect true thyroid hormone status. I would like to call the resulting test patterns "deceptive laboratory hyperthyroidism." These patterns are misleading because of non-thyroidal alteration of one or both thyroid hormone levels. They include (1) Pseudo T4/T3 Toxicosis (both T4 and T3-RIA elevated in euthyroid patient); (2) Pseudo T3 Toxicosis (T3-RIA elevated, T4 not elevated) and (3) Pseudo T4 Toxicosis (T4 elevated, T3-RIA not elevated).

Laboratory error may produce apparent abnormality in a euthyroid person, or may reduce one or both of the hormone levels in true thyrotoxicosis. Therefore, unexpected test patterns or results may require repetition of one or more of the tests before a definitive diagnosis is made. Abnormality of the same type in two tests is more helpful for diagnosis than abnormality in only one.

Pseudo T4/T3 toxicosis found in euthyroid patients is most commonly produced by increase of thyroid hormone-binding proteins, principally TBG. The most common etiology is increased estrogens, either in pregnancy or through use of birth control pills. Both T4 and T3-RIA are elevated in many of these patients. However, in some, T3-RIA may remain in upper normal range while only T4 is elevated.[18]

Effects of TBG alterations on T4 can be counteracted in most instances by internal assay correction methods ("Normalized T4", "ETR", etc.), by the use of the free thyroxine index (FT4I), or by measuring free T4 (FT4) rather than total T4. However, since TBG alterations affect T3-RIA as well as T4, and since these procedures do not correct T3-RIA, correction only of T4 may avoid pseudo T4/T3 toxicosis but produce pseudo T3 toxicosis. This hazard can be prevented either by applying the same basic free thyroxine index formula to T3-RIA, thus generating a free T3 index, or by simply inspecting the two separate components of the free thyroxine index, the T4 and T3 Uptake. If T4 and T3U are found in the opposite ends of their respective normal ranges, this suggests artifact due to TBG alteration. Unfortunately, many laboratories which generate FT4I only report the single FT4I result without separate T4 and T3U values.

More on Toxicosis

Other causes of pseudo T4/T3 toxicosis are thyroiditis (subacute, occasionally chronic lymphocytic) and factitious (self-medication) hyperthyroidism.[12] Factitious ingestion of T4 compounds may be deliberate, may be due to prior therapy which is not mentioned by the patient, or may represent T4 included in diet control pills unknown to the patient. In both subacute thyroiditis and factitious T4 ingestion the RAIU is typically low. Spurious causes for low RAIU such as iodine ingestion or X-ray contrast media administration within the past 3-4 weeks must be excluded. Subacute thyroiditis is typically painful and accompanied by a low RAIU.[27] The erythrocyte sedimentation rate (ESR) is usually elevated (over 50mm/hour). Occasional cases of subacute thyroiditis may present as thyrotoxicosis without a painful thyroid gland. Chronic lymphocytic thyroiditis typically is associated with normal thyroid hormone blood levels, normal or decreased 24-hour RAIU, normal ESR, and increased thyroid autoantibody levels. In a few cases there is a clinical picture similar to non-painful subacute thyroiditis.[11,13] RAIU is most often normal or decreased, but may be increased. ESR is usually normal. Therefore, elevated ESR favors subacute thyroiditis rather than factitious hyperthyroidism or lymphocytic thyroiditis. Administration of TSH (TSH stimulation test) usually demonstrates normal RAIU increase in factitious hyperthyroidism, whereas little increase occurs in most cases of thyroiditis.

Other entities with thyrotoxicosis associated with low RAIU include true T4/T3 toxicosis with artifactual RAIU suppression by exogenous iodine, iodine-induced hyperthyroidism (Jod-Basedow), radiation-induced thyroid disease (RAI or external radiotherapy), and ectopic T4 production (struma ovarii).

Pseudo T3 Toxicosis may be of two types: (1) *Hyperthyroid type:* T4/T3 toxicosis with normal range T4. Such cases are uncommon. It is said that T3 may rise before T4 in early thyrotoxicosis, and T3-RIA is usually elevated to a greater degree than T4. Examples have been reported of isolated T3 elevation which eventually was joined by T4 elevation.[23] An early or mild T4 abnormality may be masked in the upper area of population normal range (if a person's normal T4 were in the lower part of population normal range, the T4 could double and still remain within normal range).

(2) *Euthyroid type:* elevated T3-RIA without hyperthyroidism. This type of pseudo T3 toxi-

Table 3

Severe Non-Thyroidal Illnesses Affecting Thyroid Tests

Cirrhosis/Severe Hepatitis
Renal Failure
Cancer
Severe Febrile Illness
Post-Surgery
Starvation/Malnutrition
Acute Psychiatric Illness
Diabetic Acidosis

cosis may be produced by increased TBG when the FT4I or equivalent TBG correction method is used. Since FT4I and FT4 values remain normal when TBG is altered, increased TBG would be associated with normal FT4I (also with normal FT4 or "corrected T4" procedures) plus artifactual increase in T3-RIA. T3-RIA may be increased alone for 1-2 hours after T3 (Cytomel) administration.[28] It may also be temporarily increased for several hours after dessicated thyroid intake.[28] Iodine deficiency of moderate degree usually has normal T3-RIA and T4 levels, although mean T3-RIA values are higher than those of normal persons.[29] In severe iodine deficiency, T3-RIA is sometimes increased, T4 may be decreased, and TSH increased.[30] RAIU is increased in iodine deficiency, providing additional potential for misdiagnosis.

Pseudo T4 toxicosis may also be of two types: (1) *Hyperthyroid type:* T4/T3 toxicosis with (temporarily) reduced T3-RIA. (2) *Euthyroid type:* TBG increase with normal or reduced T3-RIA; elevated T4 in a few patients with severe nonthyroidal illness; or T4 elevation due to certain medications.

Pseudo T4 toxicosis may be produced in patients with T4/T3 toxicosis when T3-RIA is decreased for various reasons while T4 remains elevated.[31] Pseudo T4 toxicosis is found in euthyroid persons when TBG is elevated with elevated T4 while T3-RIA remains normal or is decreased.[32] The most common causes for T3-RIA decrease in either T4/T3 toxicosis or TBG elevation are severe non-thyroidal illness[3] and effect on T3-RIA of old age.[33] Many severe illnesses, particularly when chronic (Table 3), depress T3-RIA, often to very low levels. Free T3 index also decreases, but to a lesser extent. The effect of severe illness persists for variable periods of time, and is usually due to a shift from T3 toward reverse T3 production.[34] Severe non-thyroidal illness may be associated with T4 values which are decreased, increased, or which remain within normal population range.[2] T4 most commonly displays slight or mild decrease but still remains within normal limits.[3] In a relatively small minority of patients, T4 is decreased below normal ranges to varying degrees, producing pseudo hypothyroidism (clinical euthyroidism with laboratory tests falsely suggesting hypothyroidism).[35] If T4 happens to become increased, pseudo T4 toxicosis would be produced without clinical hyperthyroidism or increased TBG (designated "T4 euthyroidism" by some investigators). TSH in severe non-thyroidal illness is most often normal but may be mildly increased. T3U may be normal or mildly increased.

In some patients with increased TBG, T3-RIA remains within upper normal range while T4 is elevated.[32] Increase in binding proteins affects T4 somewhat more than T3-RIA.[36] However, increased TBG frequently produces elevated T3-RIA as well as T4.[37]

Another factor which depresses T3-RIA but not T4 is advanced age.[33] After age 60, most T3-RIA kits have demonstrated a progressive decrease with time of approximately 10-30% (literature range 0-52%). The degree of effect differs with individual manufacturers' kits.[38] Unfortunately, very few laboratories determine age-related values for the particular kit which they use. There is general but not unanimous agreement that T4 values are not greatly changed in old age.[33,39]

Certain compounds such as ipodate (Oragrafin) and iopanoic acid (Telepaque) gallbladder contrast media decrease T3-RIA and may increase T4 somewhat.[40] Dexamethasone[3] and propranolol[41] are reported to decrease T3-RIA without affecting T4 (although there is some disagreement whether propranolol may increase T4).

It has been reported that some hyperthyroid patients with elevated T4 but normal range T3-RIA have an elevated free T3 index.[18]

One final category of deceptive hyperthyroidism may be added, that of thyrotoxic pseudo-euthyroidism. Patients with decreased TBG may have falsely decreased thyroid hormone levels which would convert elevated values to normal range assay results.[37] Severe non-thyroidal illness could affect T3 toxicosis and conceivably also T4/T3 or T4 toxicosis.

"Euthyroid" Graves' Disease

In addition to the two classic types of clinical hyperthyroidism, there is one additional form known as "isolated Graves' ophthalmopathy" or "euthyroid Graves' disease." This consists of eye signs associated with hyperthyroidism but with-

out other clinical evidence of thyrotoxicosis and with normal RAIU, T4 and T3-RIA. Evidence of true hyperthyroidism consists of reports that about 50-70% of these patients have failed to demonstrate thyroid suppression in the T3 suppression test (literature range 50-100% in several small series of patients).[42,43] About two-thirds reveal evidence of thyroid autonomy in the TRH test.[43]

The existence of deceptive laboratory hyperthyroidism with the various forms of pseudotoxicosis accentuate the need for reliable confirmatory tests. This is especially true when the patient has severe non-thyroidal illness and symptoms such as atrial fibrillation, which may be due to thyrotoxicosis.[44] At present, the two most useful confirmatory procedures for hyperthyroidism are the T3 suppression test and the TRH test. Of these, the main advantage of T3 suppression over TRH is lower cost. Major disadvantages include potential danger in persons with cardiac disease and the prolonged time period necessary for the test. The TRH test has emerged as the "gold standard" for diagnosis of hyperthyroidism. The procedure appears to be safe, with relatively minor side effects. It can be completed in less than one day and can be used in patients with severe non-thyroidal illness. The major disadvantage consists of a small minority of persons without clinical or biochemical evidence of thyrotoxicosis who are reported to demonstrate TRH test results compatible with hyperthyroidism. A relative disadvantage is the high cost of the test, although the cost is not prohibitive and is comparable to nuclear medicine scans or radiologic procedures such as laminograms or skeletal surveys.

From the preceding discussion, several conclusions seem warranted:

(1) The basic screening tests for hyperthyroidism are T4 and T3-RIA.

(2) T3-RIA results are not reliable when a patient has severe non-thyroidal illness. A normal or reduced T3-RIA result must be interpreted with caution if the patient is over age 60 or has any significant degree of non-thyroidal illness.

(3) Decreased or mildly elevated T4 results must be interpreted with caution when a patient has severe non-thyroidal illness.

(4) Free thyroxine index or free thyroxine assay provide T4 values corrected for effects of TBG alterations; but if TBG is elevated and thereby produces falsely elevated T3-RIA, a normal FT4I or FT4 result may lead to misdiagnosis of T3 toxicosis.

(5) T3 uptake is useful in two ways; for the assurance it provides when T3U is elevated in association with elevated T4, and as an indicator of TBG alterations when the results are compared with those of T4.

(6) RAIU is not recommended as a screening test, but is helpful as a followup procedure to detect factitious hyperthyroidism and thyroiditis.

(7) Thyroid scan is useful to differentiate between Graves' disease and Plummer's disease, and to help reveal thyroiditis.

(8) The TRH test may be necessary to confirm or exclude the diagnosis of hyperthyroidism when the patient has severe non-thyroidal illness, when thyroid function tests disagree, when test results are equivocal, and when test results do not fit the clinical picture. A negative test (normal test result) is reasonably conclusive in ruling out hyperthyroidism; whereas a positive test (abnormally low TSH response) provides suggestive evidence but is not completely reliable in confirming hyperthyroidism.

Thyroid Function Tests in Hypothyroidism

The physiology of thyroid hormone production in hypothyroidism is similar to that described in hyperthyroidism. Hypothyroidism may be divided into three types, depending on functional defect. Each of these categories may have various etiologies.[45] The three types are:

(1) Primary (primary thyroid T4/T3 secretion defect); (2) Secondary (pituitary TSH secretion defect) and (3) Tertiary (hypothalamus TRH secretion defect).

Serum T4 is the major screening test for hypothyroidism. T4 is low in most cases. There is some overlap in the low normal range[46] since mild, early, or subclinical cases may be included in groups of clinically normal persons used to establish the normal range. There is some evidence that nearly all hypothyroid patients within euthyroid population normal limits will have T4 values in the lower 15-20% of normal range (equivalent to 1 μg/100ml over the lower limit of normal), so that T4 results above this point should provide a relatively safe exclusion of hypothyroidism.[46,47] Laboratory error, of course, must be considered if the laboratory result does not conform to the clinical picture. If the patient specimens are kept at room temperature for more than 48-72 hours, as might happen when they are sent by mail, increase in fatty acids during transit may falsely increase T4 when competitive binding (displacement) T4 methods rather than RIA methods are used.[48] Conditions which alter T4 results, such as TBG changes, non-thyroidal illness, and certain medications must be remembered.

T3-RIA has not proven very useful in diagnosis of hypothyroidism. Most studies report a considerable degree of overlap between T3-RIA results in euthyroid and hypothyroid patients. The majority of reports indicate that one-fourth to one-third of hypothyroid patients have T3-RIA values within normal range.[3,18,46] In some cases, typically in Hashimoto's thyroiditis or after treatment of hyperthyroidism with radioactive iodine, it is thought that normal range T3-RIA is due to preferential secretion of T3 in what has been called the "failing gland syndrome."[49] Test alterations due to nonthyroidal illness, age-related decrease, and TBG alterations further complicate interpretation.

T3 Uptake has also not been very helpful in screening for myxedema,[14] with a general consensus of approximately 75-80% accuracy (however, there is considerable disagreement in the literature, with accuracy in hypothyroidism varying from 27-92%). The major benefit from its use in possible hypothyroidism is for detection of TBG abnormality.

Serum TSH assay is nearly always increased in primary hypothyroidism,[21,46] and is currently the most useful confirmatory test. Since secondary (pituitary) hypothyroidism is uncommon and dysfunction due to hypothalamic etiology is rare, TSH has even been advocated as a screening test. TSH assay has not found wider use in screening for thyroid disease because of considerable overlap in the low range between hyperthyroid and euthyroid persons. Most present-day TSH assay kits exhibit relatively poor lower range sensitivity, with lower limit of normal being close to zero. In such kits it is difficult to separate hyperthyroid values, which typically are subnormal, from zero on one hand and lower limit of normal on the other. Some euthyroid lower normal specimens demonstrate the same problem. Therefore, TSH assay has been restricted to diagnosis of hypothyroidism. TSH may be increased, usually to mild degree, in some clinically euthyroid patients with severe iodine deficiency and occasional patients with severe non-thyroidal illness.[20,30,39] There may also be mild elevation in the "failing gland syndrome" associated with Hashimoto's disease and thyroid gland treatment with RAI.[20,46]

In equivocal cases, a TSH stimulation test may be useful to confirm primary hypothyroidism or to differentiate primary from secondary or tertiary etiology.[21,50] Administration of TSH normally would more than double the baseline RAIU or T4. Failure of the thyroid to respond to stimulation strongly suggests primary gland failure; whereas normal gland response implies either a pituitary or hypothalamic problem or else some artifactual abnormality in the screening test. In most patients, however, TSH assay in conjunction with T4 is sufficient for diagnosis. The TSH stimulation test can be performed with valid results even if a patient is taking thyroid hormone.

The TSH stimulation test is performed using bovine TSH. Some persons form antibodies against this material and may undergo allergic reaction if TSH is used again. In order to avoid this possibility, some investigators use a T3 withdrawal test rather than TSH stimulation to differentiate primary from secondary hypothyroidism.[51] The patient is placed on T3 therapy for one month (instead of other therapy). T3 is then discontinued for 10 days, after which a serum TSH assay is obtained. With medication containing T4, it is necessary to wait at least four weeks after withdrawal before performing routine thyroid function tests (T4, T3, TSH) in order to allow the thyroid-pituitary-hypothalamus feedback system to regain normal equilibrium.[52]

After T3, it takes only 10 days to achieve the same effect.[51] If the patient has primary hypothyroidism, serum TSH will be elevated after 10 days without T3. TSH will be normal or decreased in euthyroid persons or those with secondary and tertiary hypothyroidism. The major drawbacks of this procedure are the long time interval necessary and the fact that not enough experience with this test has been published to ascertain how many exceptions or false results may be expected.

The TRH test has been used to differentiate secondary from tertiary hypothyroidism. A significant increase in TSH after administration of TRH should theoretically suggest a hypothalamic rather than pituitary etiology for non-primary hypothyroidism. Unfortunately, 40% of TSH hyposecretors of pituitary origin demonstrate adequate response to TRH stimulation.[53] Therefore, only proof of pituitary hyposecretion by a poor response is considered sufficiently reliable for definite diagnosis.[21]

Pseudo Hypothyroidism

Pseudo hypothyroidism may be defined as decreased T4 in a euthyroid person. This may occur with decreased TBG or TBG binding (congenital or drug-induced),[32] severe iodine deficiency,[30] occasional patients with severe nonthyroidal illness,[2,35,39] and some clinically euthyroid patients with Hashimoto's thyroiditis[13] or after thyroid radiotherapy with RAI.[54] TSH is normal in TBG decrease, but may be mildly elevated in the other conditions.[20,30,39] Lithium carbonate therapy might be included in pseudo hypothyroidism since abnormality is drug-induced, occurs in only 5% of cases, and is re-

versible; but clinical as well as laboratory indices are compatible with true myxdema.[55]

Hypothyroid pseudo-euthyroidism may occur when T4 in a hypothyroid person is artifactually increased into normal population range. This may be due to elevated TBG[32,56] or because of normal range overlap in some patients with mild hypothyroidism.[45] TSH should be elevated in most cases.

From the preceding discussion, several conclusions seem warranted: (1) The basic screening test for hypothyroidism is serum T4. Values above the lower 25% of normal range virtually exclude hypothyroidism unless TBG is increased (usually due to estrogen intake or pregnancy); (2) T3 uptake is useful to detect TBG alteration; (3) TSH assay is the most reliable single test to confirm primary hypothyroidism; (4) Certain conditions may produce decreased T4 and/or increased TSH in occasional patients without primary hypothyroidism. ◀

References

A complete list of references for "Conditions Which Affect Interpretation of Thyroid Function Tests," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Special Articles

The Rogers Criminal Responsibility Assessment Scales

By Richard Rogers, Ph.D. and James L. Cavanaugh, Jr., M.D./Chicago

This paper describes the Rogers Criminal Responsibility Assessment Scales (RCRAS) as a method of assessing psychological and situational variables critical for determining expert opinions on criminal responsibility. The scales' purposes are to establish a systematic and reliable instrument for (1) quantifying pertinent psychological variables at the time of the alleged crime, and (2) implementing a criterion based decision-making model with regard to the insanity defense. An empirical basis is necessary to improve the consistency and accuracy of expert opinions on the insanity defense. The following paragraphs review briefly the current status of forensic evaluations and discuss the development of the RCRAS through its preliminary, pilot, and field studies.

The roles and abilities of mental health professionals who participate in insanity evaluations have come under strong criticism. Both the legal profession[1] and psychiatrists[2] have expressed general displeasure with forensic evaluations and subsequent opinions. Clinically, insanity evaluations are complicated by (1) malingering, (2) the retrospective nature of such evaluations, (3) incomplete and/or conflicting records, and (4) the application of a legal standard to a mental disorder or defect. Cavanaugh[3] and Resnick[4] provide extensive discussions of these and related clinical issues.

The reliability and validity of insanity evaluations have not been sufficiently addressed. Recently, Rogers and Cavanaugh[5] have employed the Schedule of Affective Disorders and Schizophrenia,[6] an extensive semi-structured diagnostic interview, to improve reliability and validity of forensic evaluations. Empirical studies on the reliability of criminal responsibility evaluations have focused only on the final element of the evaluation: the expert opinion. For example, Raifman[7] found interrater reliability on the question of insanity to be 64.02% with individual styles of examining psychiatrists accounting for much of the variability. Stock and Poythress[8] completed an unpublished study of psychologists' reliability in rendering an opinion on criminal responsibility. The research method required one psychologist to evaluate while a second psy-

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JAMES L. CAVANAUGH, M.D., is a board certified psychiatrist and director of the Section of Psychiatry and the Law, Department of Psychiatry, Rush-Presbyterian-St. Luke's Medical Center. Dr. Cavanaugh is medical director for the Isaac Ray Center and a former president of the Illinois Psychiatric Society. He is a commissioner for the Illinois Guardianship and Mental Health Advocacy Commission, chairman of the IHA committee on mental health, member of the AMA Jail Health Project and an assistant examiner for the American Board of Psychiatry and Neurology.

chologist independently observed and rated the patient. Under these specifically controlled conditions, the outcome of the evaluations was highly consistent (Kappa r = .84). In an additional study,[9] the thoroughness and perceived value of insanity evaluation reports were evaluated by judges and attorneys, through a double-blind method. This cross-disciplinary study, while noting significant differences among professionals, underscored the general need for improved quality in insanity evaluations.

The authors found no published empirical studies on the presence and severity of psychopathology and psychiatric diagnosis in forensic assessment. Comprehensive clinical studies in general psychiatry have demonstrated low interrater reliability in traditional diagnostic interviews[10] with different diagnostic standards accounting for much of the variability.[11] Ward[12] and Spitzer, Endicott, and Robins[13] have identified specific sources of unreliability in psychiatric diagnosis.

In summary, evaluations of criminal responsibility (1) address different and complicated clinical issues and (2) demonstrate little empirical support regarding the reliability and validity of forensic diagnosis and subsequent expert opinions. Development of the RCRAS was undertaken to systematically assess psychological variables operative at the time of the alleged crime and to apply a systematic decision-making model to the assessment of criminal responsibility.

A preliminary study[14] involved the systematic application of a seven point scale for assessing the presence and severity of 11 psychological variables at the time of the alleged crime. Despite the limited sample (N = 21), the results were encouraging, with each of the 11 variables varying in the expected direction (*i.e.*, the insane subsample exhibited greater levels of psychopathology). Four variables were statistically significant: degree of *planning* and *organization* of the criminal behavior, and the presence and severity of *hallucinations* and *delusions*. The results of the preliminary study suggest that with further sophistication, a diagnostic instrument could be developed which would accurately differentiate criminally responsible and insane subsamples.

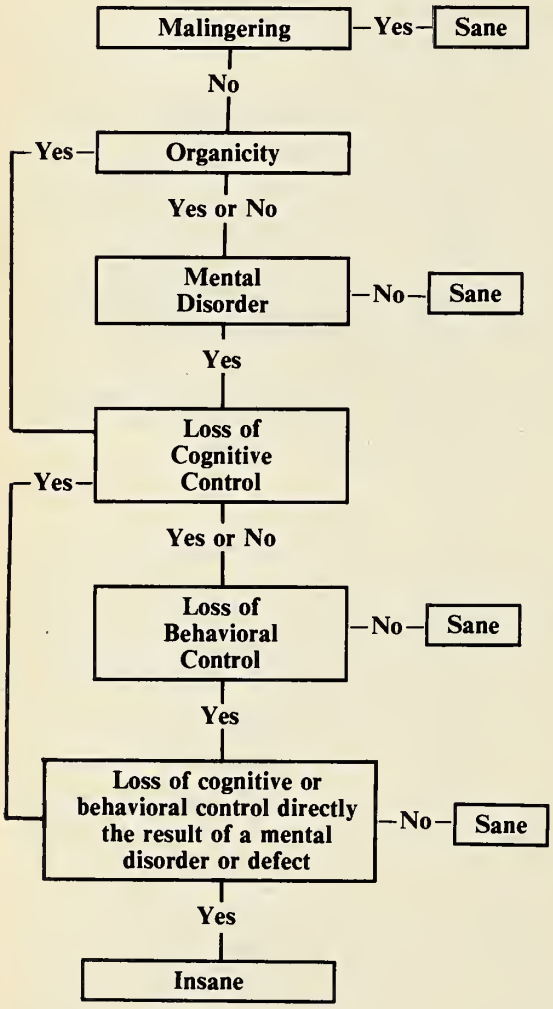
The RCRAS was developed through a revision and expansion of the preliminary study to include 23 psychological variables and a criterion-based decision model. For each psychological variable, the presence and severity of symptomatology was outlined with descriptive criteria clearly delineated. The RCRAS variables were organized into five discrete scales measuring (1) reliability of the patient's self report, (2) organicity, (3) psychopathology, (4) degree of cognitive control over criminal behavior, and (5) degree of behavioral control over criminal behavior. Examples of the individual questions for the psychological variables are included in Table 1.

Table 1
Sample RCRAS Questions

1. Planning and preparation for the alleged crime
 - (0) No information
 - (1) Elaborate planning and preparation extending over a week, with "moment by moment" plans *and* rehearsals
 - (2) Detailed planning and considerable preparation extending over at least several days
 - (3) Detailed planning with some general preparation
 - (4) Some planning which lacks specific details and timetables; little or no preparation
 - (5) Thoughts about the crime; no real planning; no preparation
 - (6) Unplanned; no forethought or preparation
2. Hallucinations at the time of the crime. (Refer to DSM III diagnostic criteria).
 - (0) No information
 - (1) Absent
 - (2) Suspected hallucinations *(e.g.* supported only by questionable self report)
 - (3) Definite hallucinations not related to the crime
 - (4) Definite hallucinations which contributed to, but were not the predominant force in the commission of the alleged crime
 - (5) Definite controlling hallucinations on the basis of which the alleged crime was committed

A hierarchical decision-making model for applying the American Law Institute (ALI) standard of insanity[15] to these specific psychological variables was established. This required that the examining clinician re-examine specific psychological variables, translate them into elements of the ALI insanity standard and, through a decision process, arrive at an expert opinion regarding criminal responsibility. The model requires hierarchical decisions about malingering, psychopathology, and the ALI standard. This is conceptualized in Table 2.

Table 2
RCRAS Decision-Making Model
For Criminal Responsibility



Pilot Study

A pilot study of the RCRAS was designed, utilizing ten diverse case vignettes from actual cases at the Isaac Ray Center. The vignette approach was selected as a brief, consistent method of evaluating the RCRAS' reliability and validity, with input data held constant. Three forensic psychiatrists and four forensic psychologists independently rated the ten vignettes and applied the decision-making model. The data derived from their evaluations were analyzed[16] with MANOVA's and item analyses (*i.e.*, sophisticated statistics for examining patterns and interactions among variables).

Initial results from the MANOVA established validity (construct validity through cluster analysis)[17] for three of the five subscales in differentiating between criminally responsible and insane case vignettes. A second analysis of the data will be executed to account for missing data in a few of the observations. An item analysis of the individual questions resulted in a median reliability coefficient of .73. These results are encouraging, considering the constraints of the vignette approach *(e.g.*, some items were not sufficiently tapped by the vignettes).

A systematic revision of the RCRAS was undertaken, employing an item analysis approach on each individual item whose $r < .80$. Changes included (1) clarification of descriptive criteria on specified psychological variables; (2) reducing the number of gradations in the severity of psychopathology to counterbalance over-refined distinctions and (3) providing brief clinical examples in areas of diagnostic ambiguity.

The field study phase has been initiated at three forensic centers employing the revised RCRAS. The purpose is to gather a total of 90 insanity evaluations, each rated on the RCRAS independently by two experienced forensic examiners. The results will be analyzed for the purpose of establishing inter-rater reliability and validity of the RCRAS instrument. It is expected that additional refinements of the RCRAS will be made from the field studies phase.

In summary, insanity evaluations represent a unique and complicated psychiatric-psychological assessment area for which there is a dearth of empirical studies. The RCRAS has been developed to quantify pertinent psychological variables at the time of the alleged crime and to implement a criterion-based decision model which translates symptomatology into a legal standard of criminal responsibility. This paper has summarized the preliminary and pilot studies and outlined the development of the field studies of the RCRAS. ◀

(Continued on page 169)

The Cancer Surgeon's Part

Breast Reconstruction After Mastectomy

By Hugh A. Johnson, M.D./Rockford

Seven suggestions are made to the cancer surgeon if the surgeon or patient are even considering reconstruction after mastectomy. Breast reconstruction following mastectomies will certainly become more common as the lesions operated become smaller due to earlier diagnosis of cancer of the breast.

"These breast cancer patients don't care about breast reconstruction, they're just happy to be rid of their cancer." That statement was made in all sincerity on our surgical section grand rounds. Yet the general surgeon saying it knew, and you and I know, that the fear of mutilation often delays the search for help when a breast lump is discovered.

Now, lay journals in their usual dramatic overstatement, are giving women the hope that multilation following breast cancer surgery is correctable. This may bring them to their cancer surgeon sooner. And perhaps the current trend[1] toward less radical procedures may become the rule with early cancer. This will certainly ease the reconstructive surgeon's task. It is appropriate that this communication comes from Rockford Memorial Hospital, where Smith and Meyer[2-4] did their retrospective studies comparing the effectiveness of the different modes of surgery.

If the patient and the general surgeon are considering the possibility of reconstruction, the following should be considered carefully.[5]



Figure 1
After insertion of the silastic implant and before the subcutaneous and enomammectomy on the right.

The length and direction of the incision.—In Halsted's day the tumors were large and involvement of chest wall was common. Perhaps this was the reason that he chose his incision. Today the indications are quite different. A transverse incision is preferable. It preserves more tissue, doesn't make axillary web contractures and is much easier to handle in the insertion of Cronin implants.[6]

Careful placement of sutures to eliminate suture marks. —Cross hatching that occurs with large, tight sutures is very difficult to conceal and very difficult to excise. Running sutures very close to the skin edges or a subcuticular and clear skin closure strips give a fine line that can be excised in the process of reconstruction.

Preservation of the nipple and areola.—There are various methods of reconstructing an areola

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Figure 2
Showing the disadvantage of the vertical incision. The nipple and aerolar complex is a split graft from the opposite normal nipple.



Figure 3
Result after Z-plasty of the web. The muscle defect can be eliminated by a custom implant, but this illustrates the difficulty in wearing normal clothing when the operation has included excision of the pectoralia muscle.

using deeply pigmented skin or the opposite areola and nipple. However, the best reconstruction is the split thickness graft of the entire nipple, aerola complex. This can be excised and the underlying tissue sent for multiple biopsy to rule out any possibility of malignancy. This complex can then be set into the dermal bed in the inguinal region just above the pubic symphysis.

Preservation of the pectoral muscles—More and more authorities are advising more conservative treatment of the muscles. If both are excised, the depression is difficult to mask, but it should be done if the surgeon feels that it is necessary. However, adequate dissection of nodes, levels one, two and three, is possible with excision of the pectoralis minor muscle only and preservation of the pecoralis major muscle.[7-11]

Thickness of the skin flaps—If there is any doubt, of course, overlying skin should be excised. Biopsies and frozen sections are helpful at the time of dissection to rule out the presence of any tumor. But in general, a thick flap lends itself more readily to reconstruction if the operation is not jeopardized by such construction.

Drain placement in the incision to eliminate drain site scars—Drains that are put through stab wounds or distant sites often give a scar that is bound down to the underlying tissue, a difficult deformity to correct. If the drains are placed in the incision but not at the ends of the incision (that is, one suture placed, then the drain and then continuous suture), removal of drains placed thus does not leave stigmata of drainage.

Early reconstruction—If the reconstruction is going to be done, it should be done as soon as the edema has subsided. There is no point in prolonging the mental anguish if the decision has already been made.

A word at this time about radiation treatment. If it has been carefully and properly done, it will have very little bearing on the reconstruction. However, if there have been complications and radiation ulceration, any reconstruction would probably best involve a latissamus dorsi (muscle) flap bringing in its own blood supply.

One final word. Authorities agree that breast cancer in the opposite breast occurs in 30% of the patients who have had a radical mastectomy before or at the age of thirty and that they ultimately die of this second cancer. One series states that 5% of all breast cancers ultimately die of cancer in the opposite breast. This brings into the discussion the possibility of removal of the breast tissue in the opposite breast at the time of reconstruction. Often this simplifies the procedure, for it makes it much easier to have symmetrically equal implants in the reconstructed and the prophylactic adenomamectomized breasts. ◀

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Rogers Criminal Responsibility Assessment

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Case Reports

Acute Myocardial Infarction and Ventricular Fibrillation During Pregnancy

By B. S. CORTIS, M.D., S. S. LEE, M.D. AND M. BACALLA, M.D./CHICAGO

The occurence of myocardial infarction during pregnancy is rare (73 cases reported) and successful cardioversion for ventricular fibrillation is rarer yet (one case).[3] In the present article, we describe a patient who experienced a myocardial infarction complicated by ventricular fibrillation during her first month of pregnancy and recovered.

A 32-year-old housewife was admitted to the emergency room with sudden onset of nausea and vomiting. She fainted within a few minutes of arrival. The ECG showed ventricular fibrillation (Figure 1). She was successfully resuscitated by repeated countershocks.

A second ECG showed an extensive antero-lateral transmural infarction (Figure 2). The CPK was 3940, the LDH 1420 and the SGOT 480; Hb13.0gr%; Hct39; WBC 14,100; RBC 4.13 millions. The serum cholesterol was 168mg%, triglycerides 62mg%, FBS 90mg%. The past history was negative for arterial hypertension or diabetes mellitus and the patient was a smoker.

Patient recovered within a month. In view of her heart condition, she was told that it would be highly advisable to have the pregnancy interrupted. The patient refused to follow this advice.

Her obstetric history revealed para 0-1-6 (?)-1 with a 2#3/4oz. premature infant. The cause of previous premature delivery was unknown and only one spontaneous abortion was proven by another physician, although the patient claimed five additional incidents.

Her LNMP was one week after admission with a menstrual cycle of 30-40 days. Excepting episodes of upper respiratory infection, the pregnancy progressed normally with a total weight gain of 22-23 lbs. Her labor was dysfunctional, requiring oxytocin stimulation. Fetal monitoring during the labor demonstrated late deceleration (Figure 3). The delivery was accomplished via low forceps on her EDC, and the female infant was 5#3oz., apparently small for date. This small for date baby could be due to maternal history of heavy smoking. The infant's apgar score was good and no gross abnormality was found on the infant. Patient later received vaginal sterilization at another institution.

Fifteen months after first admission coronary angiography demonstrated 90% occlusion of the left anterior descending branch artery before the first septal perforator branch and 80% narrowing of the proximal circumflex (Figure 4). There was also 50% occlusion of the right coronary artery in the mid-segment (Figure 5).

The left ventricular angiogram showed moderate chamber enlargement, anterior wall hypokinesia, and an apical aneurysm (Figure 6).

Discussion

Literature review revealed that while myocardial infarction during pregnancy or in the post-partum period is rare, the immediate and late mortality is disturbingly high (32%).

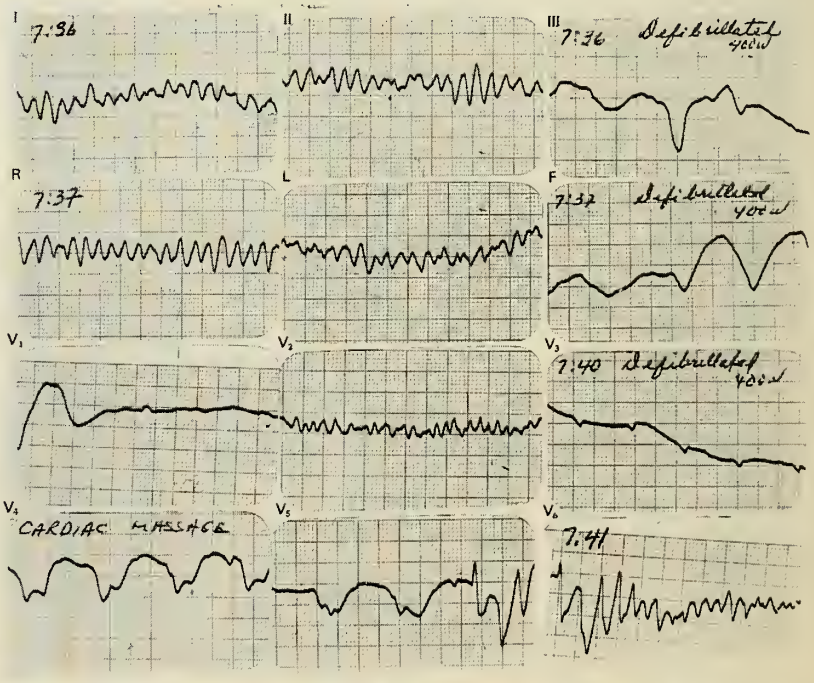


Figure 1
Rhythm strips, showing ventricular fibrillation and the changes following countershocks.

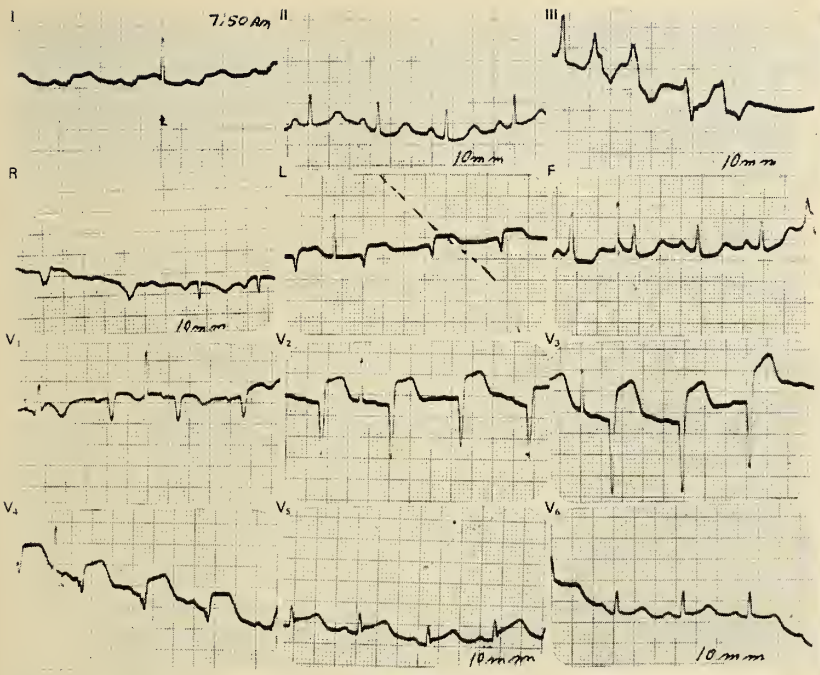


Figure 2
Electrocardiogram demonstrating an acute transmural antero-lateral myocardial infarction.

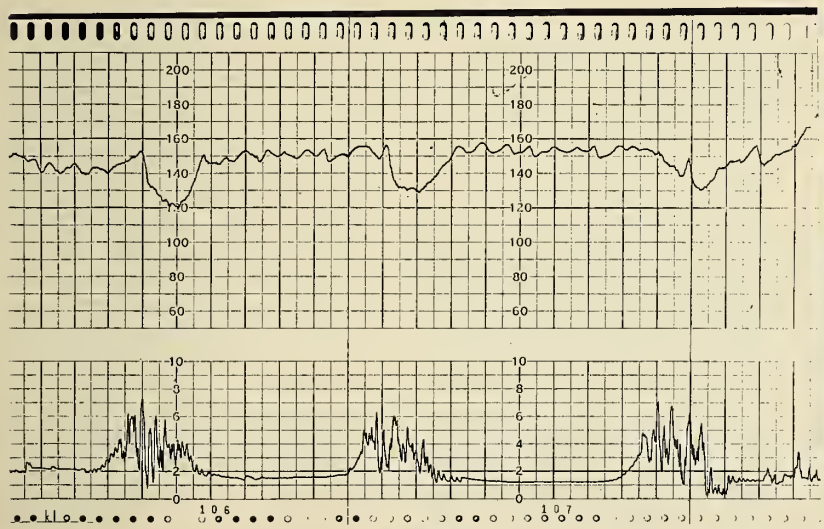


Figure 3
Internal fetal monitor graph in the first stage of labor: the above tracing showing fetal heart rate and the bottom one indicating uterine contractions. The late deceleration is demonstrated.



Figure 4
Left coronary artery arteriogram in left oblique view, showing the 90% occlusion of the left anterior descending proximally to the first septal perforator branch and 80% narrowing of the circumflex at the origin. The pacing catheter in the right ventricle is seen.

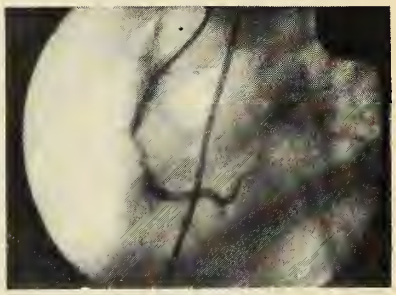


Figure 5
Right coronary artery angiogram in left oblique position, demonstrating a 50% narrowing of the mid-segment.

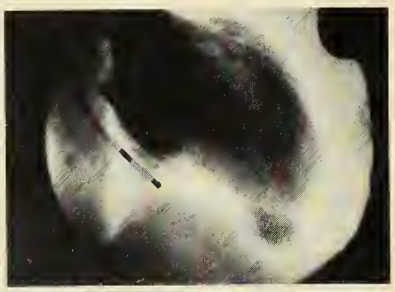


Figure 6
Left ventriculogram in right oblique view, during systole, showing anterior wall hypokinesia and an apical aneurysm. The pacing catheter in the right ventricle is also seen.

The highest incidence of infarction was observed in the group between 31-40 years of age, and during the third trimester of pregnancy.

In 1970, Curry[3] reported the first case of myocardial infarction and ventricular fibrillation treated by countershocks with fetal survival, but no diagnostic studies were performed. Sasse, *et.al*[11] (1975) reported two patients with transmural infarction and normal coronary angiograms.

In our patient the unusual features are: occurrence of myocardial infarction during the first trimester, successful recovery after defibrillation, severe degree of coronary arteriosclerosis, development of an apical ventricular aneurysm, intrauterine growth retardation, and late deceleration on fetal monitor graph. In our patient, we didn't perform nuclear cardiology studies prior to

(Continued on page 174)

Case Reports

Electrocardiographic Changes in Oral Penicillin Anaphylaxis

TIEN C. CHENG, M.D. AND J. MAURICE POUGET, M.D./
WAUKEGAN AND CHICAGO

Anaphylactic reactions to parenteral administration of penicillin have been well documented and described. Such reactions, however, following oral ingestion of penicillin, appear to be rare and less well documented. Recently, we had the opportunity to observe a patient who collapsed after taking one tablet of oral penicillin V (250mg) and showed unusual electrocardiographic changes during that episode. The purpose of this report is to describe this unusual clinical observation.

The patient, a fifty-year-old black male, suddenly developed itching, light headedness, dyspnea, wheezing and tightness in the chest shortly after taking one tablet of oral penicillin V. He collapsed and was rushed to the hospital emergency room where he was found to be conscious but markedly dyspneic and diaphoretic. There was no palpable pulse and blood pressure was unobtainable. The skin showed a diffuse erythematous rash. There was no cyanosis. On examination of the chest there were loud inspiratory and expiratory wheezes bilaterally and throughout both lung fields.

Treatment for anaphylactic shock was promptly started with oxygen, epinephrine 0.5ml of 1/1000 sol. IV, hydrocortisone sodium succinate (Solu-cortef) 100mg IV and 5% dextrose solution infusion. A 12 lead electrocardiogram (Figure 1) taken a few minutes later showed a sinus tachycardia at a rate of 132 per minute, left bundle branch block and frequent ventricular premature contractions.

The patient began to show improvement with lessening dyspnea and wheezing and return of palpable pulses and blood pressure. He was transferred to the medical intensive care unit, where physical examination several hours later showed an alert and conscious man in no acute distress. The pulse was regular, 82 beats per minute, and blood pressure was 132/80. The skin was warm and moist. The chest was clear to percussion and auscultation. Cardiac examination revealed no murmur and no extra heart sound. X-ray of the chest was normal. A repeat electrocardiogram (Figure 2) at this time showed a sinus rhythm and normal conduction. The previously noted left bundle branch block and premature ventricular beats were no longer present.

Further history taken at this time revealed that the patient had received two previous injections of penicillin for gonorrhea three years before without any ill effect and that he had received no antibiotics since. He gave no history of asthma or previous allergic reactions and no history of underlying cardiac disease.

The patient's course in the hospital was uneventful. CBC, urinalysis, BUN, SGOT, SGPT, LDH, electro-

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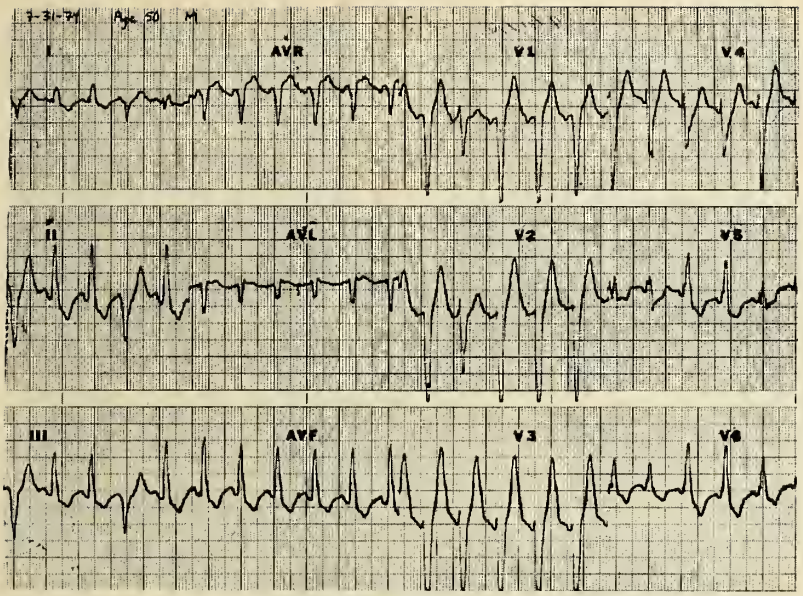


Figure 1
ECG obtained a few minutes after he collapsed showed sinus tachycardia at a rate of 132 per minute, left bundle branch block and frequent ventricular premature contractions.

lytes, 12 lead electrocardiograms and chest X-ray were all within normal limits. He was discharged four days later.

Discussion

Though not previously reported after oral penicillin, electrocardiographic changes during an acute anaphylactic reaction following parenteral injection have been described by a number of observers. These changes have included flattening or inversion of the T wave, ST segment elevation or depression, sinus tachycardia, frequent atrial or ventricular premature contractions, atrial fibrillation[1-4] and right or left bundle branch block.[5] The mechanism of these changes is not clearly understood. While some authors have postulated that these changes may be due to myocardial insult secondary to participation of the heart in the anaphylactic response,[6] other possibilities include the effect of treatment with epinephrine, manifestation under stress of underlying heart disease, or a secondary effect of hypoxemia and hypotension.[7] The very rapid and frightening course of the systemic anaphylactic reaction usually gives little, if any, opportunity for planned investigation.

Autopsy data in human anaphylaxis are few and inconclusive. Occasional observations of focal necrosis, focal hemorrhage and periarteritis[8] as well as absence of significant morphologic abnormalities have been described.[9-10] In experimentally induced anaphylactic shock, electrocardiographic as well as autopsy changes have been more consistently observed.[11]

These changes, however, could not be differentiated from those which may be induced in the same animals by asphyxia and shock, two prominent manifestations of the anaphylactic response.

It is well known that large doses of epinephrine in experimental animals and men can produce flattening or inversion of the T wave with ST segment depression in the electrocardiogram. It is thought that these changes are the result of myocardial ischemia secondary to inability of the coronary circulation to keep up with the tremendous increases in myocardial oxygen requirements induced by the catecholamine. Indeed, under these circumstances, myocardial necrosis and subendocardial infarction have been experimentally produced. In our case, however, the patient only received a small dose of epinephrine

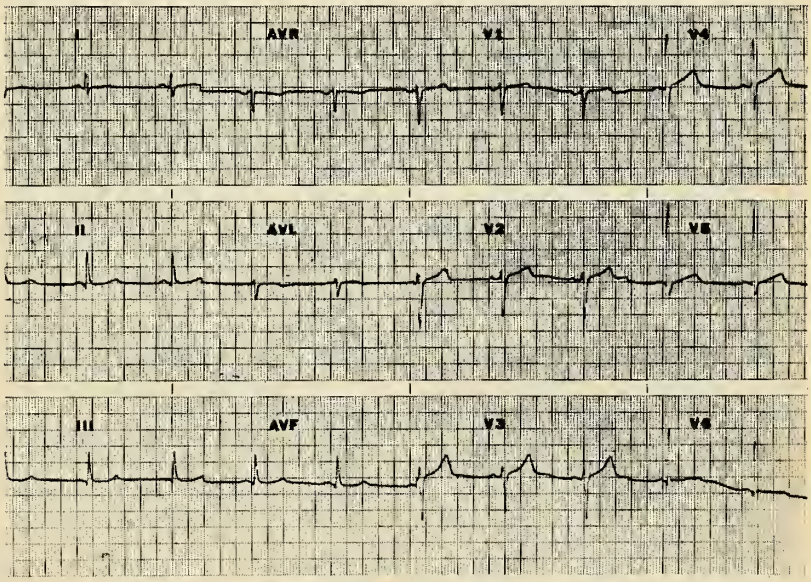


Figure 2
Repeat ECG several hours later showed a sinus rhythm rate of 87 per minute. No significant abnormality seen.

(0.5ml of 1/000 Sol) which would be unlikely to produce significant myocardial ischemia. The occurrence of left bundle branch block noted in our patient was not readily explained.

In an attempt to elucidate the mechanism of the transient electrocardiographic abnormality during anaphylaxis, the patient was rehospitalized several weeks later for further investigation. In the course of electrophysiologic studies, intermittent rate-dependent left bundle branch block as well as an abnormal refractory period of the left bundle branch could be demonstrated. Thus, what appeared to be a cardiac manifestation of the acute anaphylactic reaction could well have been merely the uncovering of a latent conduction abnormality.

Cardiac evaluation in the future should provide more precise information concerning the role cardiac abnormalities play in influencing the morbidity and mortality of patients with anaphylaxis.

This report emphasizes the need for caution in the interpretation of transient electrocardiographic abnormalities in acute clinical situations. ◀

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Acute Myocardial Infarction

(Continued from page 171)

coronary angiography because they were not available. At present we do recommend the use of this noninvasive technique as initial approach: in fact, myocardial imaging with radionuclide angiography offers detailed anatomical and functional evaluation of ischemic heart disease during the acute and convalescent period.[12]

Summary

A 32-year-old woman who experienced myocardial infarction and ventricular fibrillation during her first month of pregnancy is reported; the patient was successfully cardioverted.

Five months after delivery, coronary angiography showed severe coronary artery disease and an apical, ventricular aneurysm.

In any patient who had myocardial infarction during pregnancy, myocardial imaging with radionuclide techniques will provide anatomical and functional evaluation of ischemic heart disease. In addition, cardiac catheterization should be performed about two months after delivery to assess the degree of coronary arteriosclerosis: if severe involvement is found, further pregnancies should be discouraged and surgery considered, when indicated.

Conclusion

We emphasize the need for close cooperation between the obstetrician and cardiologist during the critical period of the myocardial infarction. We recommend the use of myocardial imaging with radionuclide techniques for the initial evaluation of ischemic heart disease.

Coronary angiography should be performed about two months after delivery to determine the degree of coronary artery disease.

If severe involvement is found, further pregnancies should be discouraged and myocardial revascularization applied when indicated. ◀

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A complete list of references for "Acute Myocardial Infarction and Ventricular Fibrillation During Pregnancy," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Surgical Grand Rounds

John M. Beal, M.D., Contributing Editor

Surgical Grand Rounds are held weekly on Tuesday, 5:00 pm in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of August 26, 1980.

Takayasu's Disease

Dr. William Flinn: A 31-year-old Korean woman had experienced a profound left hemicerebrovascular accident five years prior to her present hospitalization which had left her comatose with hemiparesis at that time. One year prior to the present admission, the patient had a residual mild right arm paresis and was admitted to another hospital with complaints of intermittent dizziness and blurring of vision. These complaints continued, and, at the time of the present admission, she complained of severe syncopal attacks, intermittent blurring of vision of both eyes and an increasing exercise intolerance in her left hand. Physical examination revealed normal motor function and normal pulses in the right upper extremity. Brachial, radial, and ulnar pulses were absent in her left upper extremity. Neither right nor left common carotid pulses were present. Doppler examination of her extremities revealed a systolic pressure of approximately 130mmHg in the right arm and in both ankles. Pulsatile flow was present in her left brachial artery with a systolic pressure of 90mmHg. Oculoplethysmography was performed, which revealed bilateral eye pulse delay, suggestive of bilateral carotid artery stenosis. Complete blood count revealed a hemoglobin of 13.0gm; hematocrit 39%; white blood count, 8700 with a normal differential. Urinalysis was normal, as was SMA-20 blood chemistry profile. Serum cholesterol and triglyceride levels and lipoprotein electrophoresis were normal. Erythrocyte sedimentation rate was 27mm per hour; however, LE prep, ANA and RF were negative. Chest X-ray and electrocardiogram were normal.

A clinical diagnosis of Takayasu's disease was made and more extensive radiographic evaluation was carried out. Arch aortogram revealed complete occlusion of the left common carotid and left subclavian arteries at their origin. (Figure 1) The innominate and right subclavian arteries appeared radiographically normal; however, there was a diffuse narrowing of the right common



Figure 1
Arch aortogram demonstrates complete occlusion of the left common carotid and left subclavian arteries.

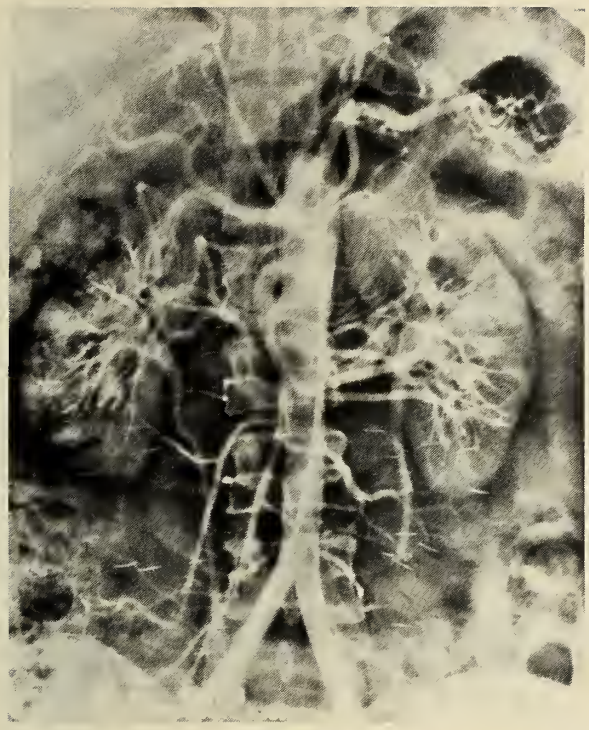


Figure 2
The abdominal aortogram is normal, with good visualization of renal arteries.



Figure 3
The left lower lobe pulmonary artery is occluded on the pulmonary angiogram.

carotid artery. Both right and left carotid bifurcations were patent and the internal and external carotid arteries appeared normal. The left carotid bifurcation filled via numerous arterial collaterals in the neck, a pattern typical of Takayasu's disease.

Abdominal aortography was also performed because the abdominal aorta, as well as its major branches below the diaphragm (most commonly, the renal arteries), may also be involved in Takayasu's disease. In this patient, the abdominal aortogram was normal.[1] (Figure 2) Additionally, from 10%-20% of the patients with Takayasu's disease may have involvement of the pulmonary arteries; thus, pulmonary angiography is an essential component of a thorough diagnostic evaluation in these patients. Pulmonary angiography revealed occlusion of the left lower lobe pulmonary artery in this patient. (Figure 3)

Discussion

Takayasu's disease is rather uncommon within the broader spectrum of brachiocephalic arterial occlusions. These may include giant cell arteritis, syphilitic aortitis and other forms of aortic degenerative disease, as well as the common atherosclerotic occlusions of the major branches of the aorta. Perhaps more pertinently, they may include arterial occlusions secondary to abnormalities of the thoracic outlet. Takayasu's disease is seen most commonly in young Oriental females and has been extensively described in the Japanese and Far Eastern literature. The experience with occlusive disease of the aortic arch and its major branches has become progressively more extensive in this country.[2]

The natural history of this particular component of brachiocephalic occlusive disease is very dismal for patients who are debilitated by strokes, profound cerebrovascular insufficiency and the symptoms of global cerebral ischemia. Untreated, these symptoms progressively worsen and long-term survival is limited in these young patients.

Surgical therapy in this patient was designed to relieve her symptoms of diffuse cerebral ischemia, prevent recurrent cerebral infarction, and relieve her functionally debilitating left arm claudication. Patients with atherosclerotic occlusion of major aortic arch branches often can undergo extra-anatomic vascular reconstruction for definitive treatment. Thus, carotid-subclavian bypass or axillary-axillary bypass via subcutaneous tunnels have evolved, with an attendant morbidity much lower than in direct reconstruction via thoracotomy or sternotomy and comparable long-term patency rates. In patients with Takayasu's disease, however, extra-anatomic reconstruction for definitive relief of symptoms is contraindicated, since disease progression in the

donor native artery may subsequently cause failure of the reconstruction.[3] In this patient, we elected to place aorta-to-left axillary and left carotid artery bypass grafts.

Surgical Procedure

The first step in operative management of this patient was to define the most proximal portion of her left axillary artery which had not been visualized on the preoperative arteriogram. An intraoperative retrograde left brachial arteriogram revealed reconstitution of the left axillary artery via collaterals and the artery appeared to be a suitable recipient for a bypass graft.

Through a standard transverse infraclavicular approach, the left axillary artery was isolated. Proximal and distal control of a portion of normal-appearing vessel was then obtained. The left carotid bifurcation was exposed through a transverse skin-line incision. Control of the left common, external and internal carotid arteries was obtained. Through a midline sternotomy, the ascending aorta was exposed and was not clinically diseased.

A Dacron bifurcation prosthesis which might normally be used for aortobifemoral reconstruction was chosen and reversed so that the proximal portion was anastomosed, end-to-side, to the ascending aorta. One limb of the reversed bifurcation graft was then passed through a left transpleural tunnel, through the second intercostal space and into the left axilla, where it was anastomosed to the left axillary artery. (Figure 4) The remaining limb was passed through the thoracic inlet, and beneath the strap muscles into the neck, where it was anastomosed to the left carotid bifurcation. In the recovery room, strong left radial and left superficial temporal pulses were indicative of satisfactory graft function.

The relief of cerebral symptoms in this patient was striking. Within 72 hours post-operatively, she was ambulatory without assistance, a feat which had been virtually impossible preoperatively because of dizziness. Left arm function has returned to normal. Arch aortography was performed prior to discharge from the hospital and revealed the graft to be patent.

Summary

While this patient's problem was somewhat unusual, a thorough history and physical examination would certainly make one suspicious. Comprehensive angiographic evaluation of these patients, including arch, abdominal and pulmonary angiograms, is essential for optimal therapeutic management. Surgical treatment, where indicated, can be expected to provide excellent symptomatic relief. The long-term prognosis in these cases is, at present, uncertain since the number of cases of Takayasu's disease treated in this country has been limited.

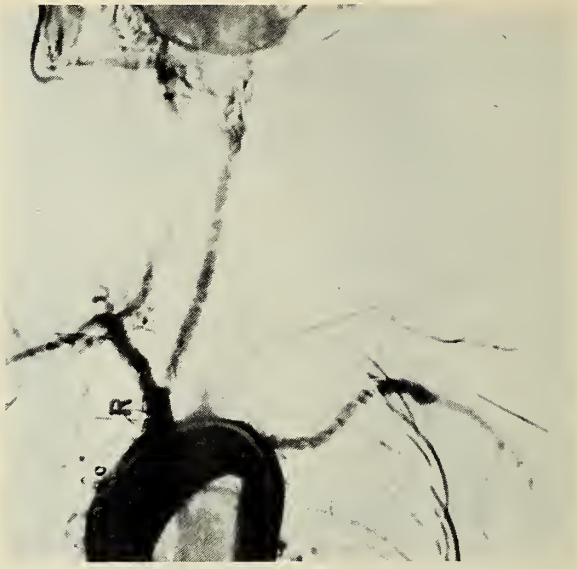


Figure 4
Postoperative aortogram demonstrates functioning reversed bifurcation graft, to left axillary artery and to left carotid bifurcation.

It is particularly timely that we discuss upper extremity and brachiocephalic occlusions, especially in light of what has recently happened to one of the professional baseball players. It is clear that this particular man's definitive diagnosis and treatment were delayed for what would be considered an inordinate amount of time. Takayasu's disease is, of course, a rather unusual etiology for this problem. Nevertheless, I think we must maintain a high level of diagnostic suspicion in patients with diffuse cerebral symptoms and unusual upper extremity symptoms, in spite of the fact that they may be very young and one might not expect them to have arterial occlusive disease. The overall surgical treatment of this patient was gratifying, and it behooves us to pay attention to these particular symptomatic complaints, even in young patients. ◀

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Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Mrs. E. Duffy, Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

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Doctor's News

RESOLUTIONS DEADLINE—The ISMS House of Delegates' Interim Session is scheduled for November 7-8, 1981, in Springfield. Resolutions for the House of Delegates must be *received* in the ISMS offices by October 8, 1981. Resolutions received after that date will be considered late resolutions and require special action for possible consideration.

In accordance with a resolution passed at the 1978 Annual Meeting, resolutions will be published in the *Journal* by author and subject only. In order to be published in the *Journal,* resolutions must be *received* in the ISMS offices by an earlier deadline, September 3.

PANCREATIC CANCER TREATMENT—Isidore Cohn, Jr., M.D., project director, National Pancreatic Cancer Project, has announced availability of that center's resources to primary care physicians. The Project, which is funded by the National Cancer Institute to stimilate research in pancreatic cancer, maintains current information on new approaches to diagnosis and treatment and individuals or institutions participating in advanced protocols. Information available from the project includes that regarding institutions with highly specialized facilities, some of which provide transportation and medical care at no cost to the patient.

Dr. Cohn has emphasized that Project staff are available to any patient, patient's family or primary care physician, but will in no instance interfere with the physician-patient relationship. Patients who seek assistance will receive information from the project only through their primary care physician.

Further information may be obtained by writing Dr. Cohn at the Louisiana State University Medical Center, 1542 Tulane Ave., New Orleans LA 70112; (504) 522-4571.

NUCLEAR ENERGY SAFETY is the subject of a report by an advisory panel to the AMA Council on Scientific Affairs that was approved by the 1981 Annual Meeting House of Delegates. *Risks of Nuclear Energy and Low-Level Ionizing Radiation* considers peaceful uses of nuclear energy and standards for exposure to ionizing radiation. The report urges modification of local laws to permit the disposal of low-level radioactive waste in accord with AMA model state legislation. AMA has recommended the report as a backgrounder for physicians seeking information for patients about the effects of radiation on health. Copies may be obtained by writing Order Dept. OP-125, AMA, PO Box 821, Monroe Wisconsin 53566. Correspondents should enclose $4.50 for postage and handling.

JCAH PUBLICATIONS UPDATED—The Joint Commission on Accreditation of Hospitals (JCAH) recently published the 1982 edition of the *Accreditation Manual for Hospitals.* The manual features administrative policies and procedures governing accreditation surveys, patient rights and responsibilities, standards for 24 key areas of hospital operations and an appendix describing differences between 1981 and 1982 standards. Companion volumes of the *PHAS Manual* (eighth edition) and *Hospital Survey Profile* are also available.

JCAH has also revised their official newsletter, *JCAH Perspectives.* The newsletter will regularly contain articles on the application of new standards, and preparation for a successful accreditation survey.

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Guide to Continuing Medical Education

Compiled for Illinois physicians by the Illinois Council on Continuing Medical Education, 55 E. Monroe St., Suite 3510, Chicago IL 60603; (312) 236-6110

Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

OCTOBER

Cardiac Rehabilitation

Comprehensive Cardiac Rehabilitation Workshops
For: Primary Care Physicians. Workshop, October 12-26, La Crosse, WI. **Sponsor:** La Crosse Exercise Program, Workshop Unit, Mitchell Hall, University of WI, La Crosse, WI 54601. **Fee:** $450. **Reg. limit:** 50. **Credit:** Category 1, 38 hours; AAFP Prescribed, 43 hours. **Contact:** Dr. Philip Wilson. **Phone:** 608/785-8686.

Chemical Dependence

Physician's Workshop
For: MD's. Conference, Oct. 2, Holiday Inn City Center, Chicago. **Sponsor:** Northwestern Memorial Hospital, 320 E. Huron St., Chicago 60611. **Fee:** $75. **Credit:** Category 1, 7 hours applied for. **Contact:** Kenneth Tortoriello, PhD. **Phone:** 312/649-8713.

Child Abuse

Spend a Day to Prevent Child Abuse
For: MD's. Symposium, Oct. 28, Chicago. **Sponsor:** Mt. Sinai Hospital, 15th St. and California Ave., Chicago 60608. **Reg. deadline:** 10/22. **Fee:** $25. **Reg. limit:** 200. **Credit:** Category 1, 5½ hours. **Contact:** S. Jones. **Phone:** 312/542-2563.

Camputers in Medicine

Choosing and Using a Computer System in a Private Medical Practice
For: MD's. Seminar, Oct. 16-17, Hyatt Regency Hotel, Woodfield. **Speaker:** Ronnie Beth Bush, PhD. **Sponsor:** University of Health Sciences/The Chicago Medical School, c/o One Chapman Road, Burlington 60109. **Fee:** $295. **Credit:** Category 1, 16 hours. **Contact:** Connie Scott. **Phone:** 312/683-2066.

Emergency Medicine

A Postgraduate Institute for Career Emergency Physicians
For: Emergency Physicians. Symposium, Oct. 12-16, Detroit, MI. **Sponsor:** Wayne State University School of Medicine, CME, 9B-32 DRHUHC, 4201 St. Antoine, Detroit, MI 48201. **Fee:** $500. **Reg. limit:** 20. **Credit:** Category 1, 35 hours; ACEP, 35 hours. **Phone:** 313/577-1180.

Family Medicine

Peptic Ulcer—Diagnosis and Treatment
For: MD's. Lecture, Oct. 21, 12:30 p.m., DuPage County. **Speaker:** Marshall Sporberg, MD. **Sponsor:** DuPage County Medical Society, 26 West St. Charles Rd., Lombard 60148. **Reg. deadline:** 10/19. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours; AAFP Elective, 2 hours. **Contact:** Lillian Widmer. **Phone:** 312/495-4050.

Medicine

Psychiatry Update: A Symposium for Physicians and Mental Health Professionals
For: MD's. Symposium, Oct. 28, Springfield. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

OB/GYN Symposium
For: MD's. Symposium, Oct. 29, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217-782-7711.

Medicine

Appropriate Antibiotic Usage
For: MD's. Symposium, Oct. 8, 1:00 p.m., Pittsfield. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Cotegory 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

8th Annual Family Practice Review
For: MD's. Symposium, Oct. 9-10, Springfield. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Professional Burn-Out Symposium
For: MD's. Symposium, Oct. 22, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Advances in Cardiovosculor Disease 1981
For: MD's. Lecture, Oct. 16-17, Chicago Morriott Hotel. **Sponsor:** Div. of Cardiology, University of Health Sciences/The Chicago Medical School, 3333 Green Bay Road, North Chicago 60064. **Reg. deodline:** 9/15. **Fee:** $20. **Credit:** Category 1, 11 hours. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/689-8010 x 233.

Neuralagy

Neurology Conference
For: MD's. Lecture, Oct. 10, 8:00 a.m., Iowa City, IA. **Sponsor:** UI College of Medicine, CME, 285 Med Labs, Iowa City, IA 52242. **Fee:** yes. **Reg. limit:** 200. **Credit:** Category 1, 4 hours. **Contact:** R. M. Coplan, MD. **Phone:** 319/353-5763.

Neuralagy

Contemporary Topics in Neurology
For: Neurologists, Psychiatrists. Lecture, Oct. 12 (5 days), Chicago. **Speakers:** Sondro Olsen, MD; Frank Rubino, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $375. **Reg. limit:** 85. **Credit:** Category 1, 42 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Psychiatry

Contemporary Topics in Psychiatry
For: Psychiatrists, Neurologists. Lecture, Oct. 26 (5 doys), Chicago. **Speaker:** Francois Alouf, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $375. **Reg. limit:** 125. **Credit:** Category 1, 40 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Advanced Peripheral Vasculor Surgery
For: Peripheral Vosculor Surgeons. Lecture, Oct. 26 (5 days), Chicago. **Speakers:** D. Preston Flanigan, MD; John Bergan, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $350. **Reg. limit:** 80. **Credit:** Cotegory 1, 34 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Surgery

Specialty Review in Surgery, Part I
For: General Surgeons. Lecture, Oct. 26 (11 days), Chicago. **Speaker:** Robert Baker, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $600. **Reg. limit:** 400. **Credit:** Category 1, 98 hours. **Contact:** Robert Boker. **Phone:** 312/733-2800.

Surgery

Chicogo Inter-Hospital Traumo Conference
For: Surgeons, Emergency Room Physicions. Case Presentations, 4:30-6:00 p.m., second Friday of month, The Chicago Athletic Assn., 12 S. Michigon Ave. **Sponsor:** CITC group. **Fee:** none. **Reg. limit:** none. **Credit:** pending. **Phone:** 531-3454.

NOVEMBER

Anesthesialagy

Regional Anesthesio
For: Anesthesiologists. Lecture, Nov. 2 (5 doys), Chicago. **Speaker:** Alon Winnie, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $400. **Reg. limit:** 20. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Family Medicine

Manogement of the Acute Cardiac Patient
For: FP's. Lecture, Nov. 4 (3 doys), Chicago. **Speaker:** Kenneth Rosen, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $250. **Reg. limit:** 80. **Credit:** Category 1, 20 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

Family Medicine

Rise and Fall of the Physician's Sex Life
For: MD's. Lecture, Nov. 18, 12:30 p.m., DuPage County. **Speaker:** Domeena Renshaw, MD. **Sponsor:** DuPage County Medical Society, 26 West St. Charles Rd., Lombard 60148. **Fee:** none. **Reg. limit:** none. **Reg. deadline:** 11/16. **Credit:** Category 1, 2 hours; AAFP Elective, 2 hours. **Contact:** Lillian Widmer. **Phone:** 312/495-4050.

Internal Medicine

Clinical Allergy for Practicing Physicians
For: MD's. Symposium, Nov. 5-7, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box B063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $160. **Reg. limit:** 150. **Credit:** Category 1, 15 hours; AAFP Prescribed, 15 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/454-3873.

Medicine

Dermatology Symposium
For: MD's. Symposium, Nov. 19, 1:00 p.m., Beardstown. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Sexually Transmitted Diseases
For: MD's. Symposium, Nov. 18, 1:00 p.m., Marion. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Outpotient Gynecology Symposium
For: MD's. Symposium, Nov. 12, 3:00 p.m., Quincy. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

What's New in Chemotherapy
For: MD's. Symposium, Nov. 10, 7.00 p.m., Effingham. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Adolescent Medicine
For: MD's. Symposium, Nov. 5, 7:00 p.m., Ina. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Springfield 62708. **Reg. limit:** none. **Credit:** Cotegory 1, 3 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Seminars in Immunopathology and Oncology

Richard J. Ablin, Ph.D., Contributing Editor

Beta$_2$-Microglobulin In Cancer

By A.J. Pesce, Ph. D., M. A. Weiss, M. D., L. DiPersio, M. S., and J. G. Michael, Ph. D./Cincinnati

Discovery of B_2m stemmed from observations of Friberg, who noted that workers exposed to cadmium fumes excreted low molecular weight proteins in urine.[1] After several years of effort, Berggard and Bearn[2] isolated B_2m from the urine of these patients. The physical and some of the biological properties of the molecule have been characterized (Table 1).[3-5] B_2m is comprised of a single polypeptide chain of about 11,800 daltons containing 100 amino acids. It has a single disulfide loop, but does not have any carbohydrate moieties. The human protein consists of two homologues with isoclectric points (pI) of 5.3 and 5.7.[6]

In a series of ingenious experiments, Bernier and Fanger showed that B_2m molecule is synthesized by lymphoid tissues and it was demonstrated that this molecule is localized on the surface of cells.[7-11] Poulik and Bloom[12] identified the presence of B_2m on human lymphocytes, platelets, polymorphonuclear cells (PMN) and cell lines originating from embryonic lung, mammary carcinoma, amniotic fluid, skin and testes but not on the mature erythrocyte. From these and other studies, it was concluded that molecule was apparently expressed on all nucleated cells and it serves as a glue to anchor the HLA antigen. An artistic representation of this structural relationship is given in Figure 1. In 1971, a radioimmunoassay for B_2m was developed[13] and the use of B_2m as a marker diverged in two directions: in nephrology as a marker in renal disease, and in oncology as a potential marker in cancer diagnosis.

The use of B_2m as an index of renal dysfunction was developed by Peterson, *et al.*,[14] who studied its clearance in patients with glomerular and tubular disease. In tubular disease the urinary excretion of this protein increases greatly and under extreme circumstances it can be 1,000 times greater than in normal urine. This occurs since the kidney is the major pathway of metabolism of this macromolecule. Because of its small size it is readily filtered at the glomerular level and 99% is reabsorbed by the proximal tubule. The serum level varies inversely with renal function—

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J. GABRIEL MICHAEL, Ph.D., is o professor of microbiology and immunology ot the University of Cincinnoti College of Medicine. An editoriol reviewer for the *Journal of Immunology, Investion and Immunity* os well os the *Journal of Infectious Diseases,* he holds severol fellowships and memberships in professionol ossociotions.

LINDA P. DiPERSIO is o reseorch ossistont ot the University of Cincinnoti Medical Center. Ms. DiPersio holds o mosters' degree ond cites speciol interest in concer immunology.

MARK A. WEISS, M.D., is o boord certified onotomic pathologist and diplomote of the Notionol Board of Medicol Exominers. An ossociote professor of pothology, surgical pothology ond nephropothology at the University of Cincinnati Medicol Center, Dr. Weiss is offiliated with the university hospitol ond cites porticulor emphosis in surgicol/renol pothology ond cancer reseorch.

Table 1

Properties of Human B_2-microglobulin

Physicol	
Moleculor size	11,800
Number of omino ocids	100
Corbohydrote content	None
Isoelectric point (two forms)	5.3, 5.7
Biologicol	
Locotion	Introcellulor, extrocellulor ond cell membrone
Function	(Proposed) To onchor HLA ontigen to cell surfoce membrone
Structurol Anology	To constont portion (C_3H) of IgG molecule
Metobolism	Kidney
Glomerulor Sieving Coefficient	Approximotely 100%
Plosmo Level (Normol)	1.1 to 2.4 ug/ml
Urinory Excretion (Normol)	30-370 ug/24 hours
Urinory Excretion (Abnormol)	to 100 mg/24 hours

the lower the glomerular filtration rate, the higher the B_2m level. In this circumstance, as with other small molecules, there is failure of filtration. The very narrow range of normal B_2m levels in serum (1.1 - 2.4ug/ml) with a mean value of 1.6 ug/ml

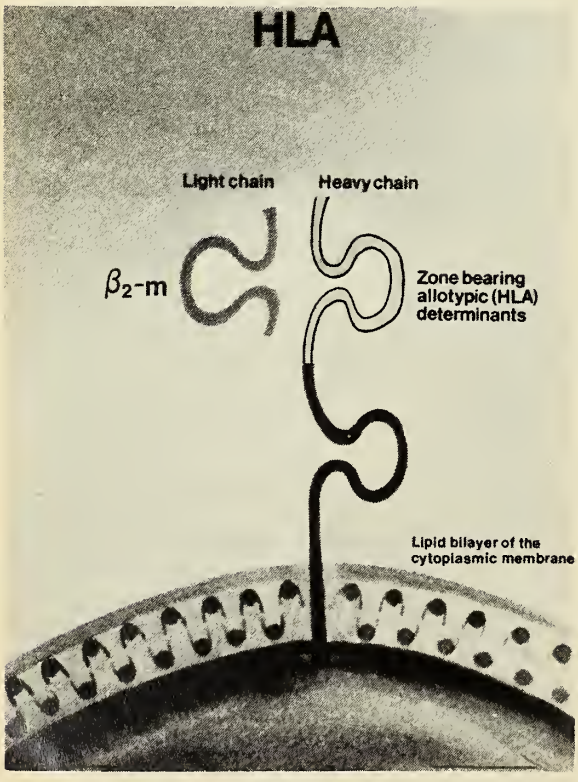


Figure 1

Artistic representation of structural relationship between B_2-microglobulin and the HLA antigen. *Reprinted from Phadadoc No. 6 by permission of Pharmacia Diagnostics, Inc.*

made possible the use of B_2m as an indicator of renal function.[15] However, there were several conditions other than renal disease which were reported to result in increased plasma levels of B_2m. These included pregnancy, inflammatory diseases and various neoplastic states. The use of B_2m in diagnosis of cancer came from these early observations of elevated B_2m in patients with malignant diseases.

In order to understand the changes in plasma levels of B_2m in cancer, it is useful to consider the data on B_2m synthesis by a number of normal and tumor cell lines. Table 2 presents a summary of the data of Nilsson, *et al.* B_2m is secreted in a narrow range by normal cells compared to the wide range from 0 to 2850ng found in the tumor cell lines. Variations within tumor types were observed for osteosarcoma (nine-fold difference) and gliomas (ten-fold secretory range). Two cell lines produced no B_2m; they were Daudi derived from Burkitt's lymphoma and RPMI 8226 obtained from a patient with myeloma. Thus, it is clear that there is a uniform secretion of B_2m by normal cells, while secretion by tumor cells varies considerably, even if the originating cell is of a single type. It is this variance which is responsible for the confusion concerning the usefulness of B_2m as a tumor marker. Table 3 summarizes B_2m data from several studies[17,26] which show no elevation of B_2m in a large number of patients. The best association of B_2m with disease state has been in patients with lymphoproliferative B cell malignancies.[26] Child, *et al.*, reported that the serum level of B_2m was elevated in later stages of Hodgkin's and non-Hodgkin's lymphomas. In remission, the B_2m serum levels fell, following the course of the disease. The wide variation in B_2m concentration in the plasma of cancer pa-

Table 2

B_2-Microglobulin Secretion by Cell Lines

Number	Cell Type	Range of Secretion[a]
10[b]	Lymphoblastaid (diplaid)	247 - 387
2	Lymphablastaid (anuplaid)	80,553
12	Lymphama	0 - 144
3	Hybrid cells lymphama-lymphama	69 - 74
2	Myelama	0 - 236
2	Osteasarcama	103 - 957
3[b]	Embryanic lung	255 - 284
6	Gliama	65 - 700
2[b]	Narmal brain	237 - 244
2	Carcinama af bladder, transitianal cell	2150 - 2850

[a] B_2-micraglabulin praductian expressed as ng/ml in culture media initially seeded with 5 x 10^5 cells and allawed ta graw far 65 haurs.

[b] Narmal cell lines

Adapted fram Nilssan, Evrin and Welsh[12]

tients is in concordance with Nilsson's observations on B_2m production in tissue culture: the existence of such differences between tumors may well have been expected.

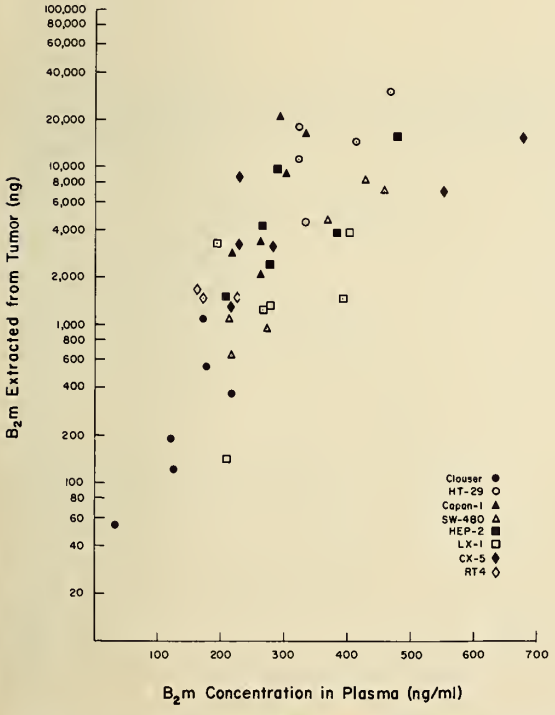


Figure 2

Plasma levels of B_2microglobulin in nude mice bearing various tumors. Each symbol represents the plasma B_2m concentration and the total B_2m extractable from a tumor (a function of both concentration and size) for an individual animal. Tumors were of the following origin: Mx-1 breast, CX-1, CX-2, CX-5 colon, HEP-2 epithelial, LX-1 lung.

Table 3

Percent of Cancer Patients with Elevated Serum B_2m Levels

Primary Lesion	Percent of Patients With Elevated B_2m[a]	Reference
Breast	15, 20, 24, 48	(17-20)
Lung	21	(21)
Calan and Rectum	40, 44, 60, 69	(20,22,23,24)
Uterine Cervix	46	(24)
Uterine Carpus	57	(23)
Bronchagenic	33	(25)
Hadgkin's Stage I, II	8	(26)
Hadgkin's Stage III, IV	47	(26)
Nan-Hadgkin's Stage I, II	23	(26)
Nan-Hadgkin's Stage III, IV	60	(26)

[a] Upper limit af narmal serum level was 2.4 ta 3.0 ug/ml

METHODS

Our own work on B_2m was initiated to resolve the problem of whether or not the plasma elevation seen in cancer patients could be the result of synthesis by the tumor rather then by host response. To do this, we implanted human tumors into athymic (nude) mice. These mice lack T cells and will accept tissue from other species (xenografts). Subcutaneously implanted tumors can be followed by simple caliper measurements and retain their human identity. We demonstrated that human B_2m can be readily identified and

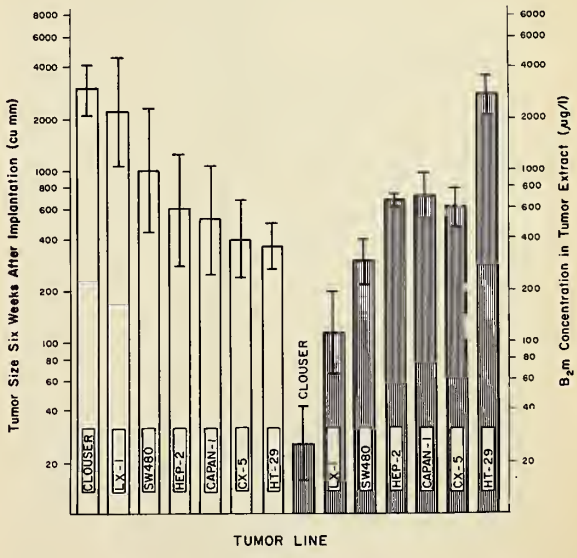


Figure 3

Growth rate and B_2m concentration of human tumors grown in athymic mice. Left panel: size of tumor 6 weeks after implantation (brackets—range of size. Right panel: B_2m concentration in tumor extract (expressed as ug/liter of extract). *Reprinted from 27 by permission of S. Karger, Basel.*

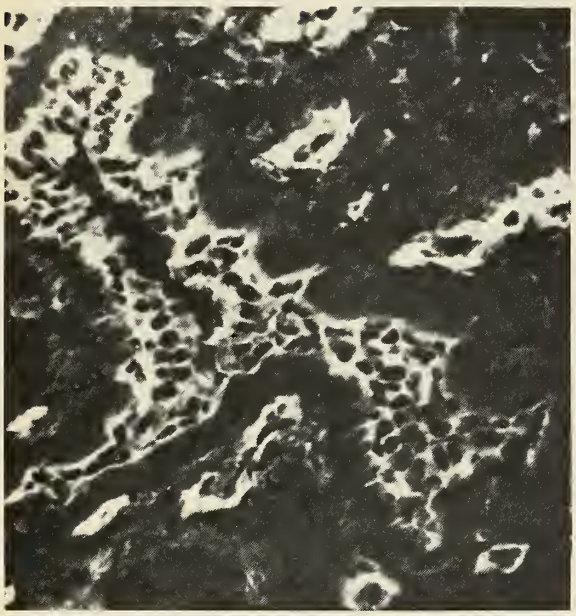


Figure 4
Benign human breast tissue fluorescence stained by anti-B_2m antibody. Note the homogeneous staining of the ductal epithelial membrane.

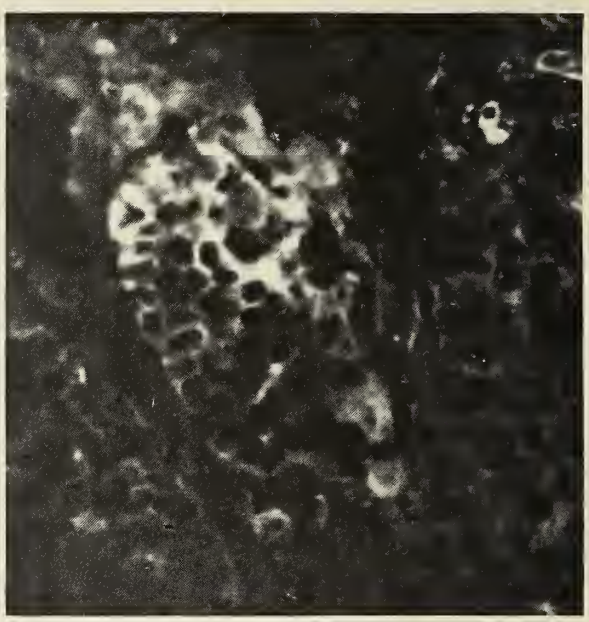


Figure 5
Human breast carcinoma fluorescence stained by anti-B_2m antibody. Note the heterogeneous intensity of the cancer cells.

quantified in the plasma of mice bearing xenografts[27,28] and the amounts released into plasma were directly related to the total quantity of B_2m extracted from the tumor (Figure 2). Thus, it was clear that B_2m release was due solely to tumor secretion.

The most striking observation in our study was the wide variance in B_2m content and secretion between the tumors, for the range of B_2m content was 100-fold (Figure 3). Upon further examination of the system, it became obvious that the tumors with the fastest growth rate contained the least amount of B_2m. By following the size of the tumor after six weeks, a ten-fold difference in growth rate could be observed between the MX-1 and the HT-29 tumor lines. When examined for B_2m content by simple extraction, the MX-1 content was 1/100 of the HT-29 tumor. In a similar manner, the other tumors were ranked according to growth rate and B_2m content (Figure 2). The use of the nude mouse model allowed studies of B_2m expression and secretion by human tumor tissue to be accomplished without the complication of B_2m production by normal tissue.[27,28]

In view of the various levels of B_2m in the plasma of patients with malignant diseases, and our results with the human tumor xenograft lines, we decided to study B_2m expression by tumor cells using the immunofluorescence technique on frozen sections of benign and malignant breast tissue.[28,29] Benign breast tissue had a homogeneous staining pattern of the ductal epithelial membrane (Figure 4). Infiltrating ductal carcinomas differ greatly in their B_2m content, and several of the most poorly differentiated carcinomas did not express B_2m at all. In addition, there are variations in staining within an individual tumor, both between nests and within tumor nests (Figure 5).

Recent studies of mouse teratocarcinoma cell lines support the concept that B_2m may be a marker of differentiation in tumor cells. Mouse teratocarcinomas under *in vitro* conditions expressed B_2m and maturation antigen only during the later stages of differentiation.[30] Also pertinent to studies of the relationship between B_2m and differentiation are recent studies showing that chronic leukemia patients have a higher B_2m serum level than acute leukemia patients.[31,32] Chronic leukemia is characterized by mature leukocytes and acute leukemia by immature ones.

Since B_2m forms parts of the human histocompatibility (HLA) antigens,[10] it may serve as a marker for the presence of these antigens. It is tempting to speculate that HLA antigens as rec-

ognition sites are part of the immunological defense system in which cells altered by viral infection, aging, or malignant transformation are destroyed. Thus, cells which fail to express HLA antigens and B_2m may also escape immune surveillance.

In summary, the available data indicate that serum levels of B_2m can be used as a marker of cancer if the tumor cells produce large amounts of the molecule, as has been found in lymphoproliferative disorders. However, a potentially more important use of this marker is in immunohistology where it may be used to characterize tumor differentiation, heterogeneity and metastatic capacity. ◀

Acknowledgements

This work was supported in part by Grants PDT-174 from the American Cancer Socicty, and CA 16939 from the National Cancer Institute.

References

A complete list of references for "Beta$_2$-Microglobulin in Cancer," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.

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Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
Pregnancy
See "WARNINGS"
Pediatric Use
Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
Anusol-HC Cream–Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.
NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.
How Supplied: Anusol-HC Suppositories–boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.
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Store between 59°-86°F (15°-30°C).
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EKG

(Continued from page 143)

Answers: 1. A. C. 2. A. C. D.

The tracing shows sinus tachycardia at a rate of 120 beats per minute interrupted by a paroxysmal supraventricular tachycardia with aberrant intraventricular conduction at a rate of 250 beats per minute. The fourth, fifth, ninth, and tenth beats in line one are examples of the sinus rhythm. The remaining beats occur at a rate that is in the range of atrial flutter although flutter did not seem to be present. The beats with the widened QRS morphology occur in short bursts at the same cycle length as the supraventricular tachycardia. Note that the widened QRS beats tend to occur when the preceding two R-R cycles are in a long cycle/short cycle ratio. The last beat following these aberrant beats at the same short cycle length often has a normal QRS duration. There is no compensatory pause following the aberrant QRS beats. Since this is lead V_1, these aberrantly conducted beats have the morphology of complete right bundle branch block. There are minor variations in the depth of the S wave during the supraventricular tachycardia. These variations represent minor degrees of aberrant conduction. The clinical diagnosis here was acute respiratory failure with CO_2 retention and acidosis. Congestive heart failure was also suspected but there were no physical findings to support it. Administration of oxygen without endotracheal intubation can be dangerous since this could worsen CO_2 retention. Endotracheal intubation with ventilation will help remove CO_2 and allow the delivery of oxygen safely. Diuretic therapy is often helpful because it reduces lung water. Our patient responded to these measures. No cardiac medications were required long term. ◀

OBITUARIES

****Goodyear, Arthur,** Decatur, died June 16, 1981, at the age of 86. A 1919 graduate of Hahnemann Medical College and Hospital, Dr. Goodyear was a highly active member and officer of ISMS.



Dr. Goodyear joined the Macon County Medical Society in 1921. A general practitioner and surgeon, he practiced in Decatur from 1920-1977. He was president of the Macon County Medical Society in 1941, a 1948-1952 member of the ISMS House of Delegates and ISMS trustee from the seventh district from 1952-1976.

Dr. Goodyear was chairman of the ISMS Board of Trustees, 1966-1968. Equally prominent in national medical circles, he served as a member of the ISMS Delegation to the AMA, 1960-1969, and chairman of that body for the period 1961-1962.

His service to ISMS included membership on the Policy, Finance, Executive and Ethical Relations committees. When he retired as trustee in 1976, the Board of Trustees presented him a special plaque in recognition of extraordinary service.

Dr. Goodyear was an avid athlete and champion swimmer who once qualified for the U.S. Olympic Team. Locally, he was medical staff president for both Decatur and Macon County hospitals, a lifetime member of the YMCA and former director of the Macon County Mental Health Clinic. Dr. Goodyear is survived by his wife, Jane, one daughter, seven grandchildren and seven great-grandchildren.

***Hall, Alice K.,** Oak Park, died July 8, 1981, at the age of 90. Dr. Hall was a 1921 graduate of the Rush Medical College.

***Hoekstra, Roger A.,** Wheaton, died July 18, 1981 at the age of 49. Dr. Hoekstra was a 1959 graduate of the University of Illinois.

****Knopp, Maurice,** Chicago, died July 11, 1981, at the age of 82. Dr. Knopp is a 1929 graduate of the Chicago Medical School.

***Levin, I. M.,** Oak Park, died July 14, 1981.

****Mandel, Robert M.,** Chicago, died July 13, 1981 at the age of 83. Dr. Mandel was a 1923 graduate of the University of Illinois School of Medicine.

***Rappolt, Lilly Alice,** Chicago, died July 10, 1981 at the age of 82.

***Silverstein, Norman,** Lincolnwood, died July 15. 1981 at the age of 77. Dr. Silverstein is a 1934 graduate of the University of Illinois School of Medicine. ◀

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PRECAUTIONS: Intraocular pressure is increased, therefore, caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur

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ONE HUNDRED YEARS WELLCOME

FEDERAL HEALTH BUDGET UPDATE — The AMA has summarized salient points of provisions agreed upon by the 41 member House-Senate Conference Committee on Health under the *Omnibus Reconciliation Act of 1981.* The conference committee succeeded in identifying three health block grants and a number of separate short term grants for special concerns.

The three health block grants address programs for prevention, health services and primary care. Some of the small, short term grants include those for family planning, child immunization, communicable disease, substance abuse demonstration projects and developmental disabilities. The conference committee set an end to health education capitation grants at FY1981 and reauthorized the National Health Service Corps under specified conditions.

The Act incorporates many complex areas of importance to physicians. A select few of these are briefly outlined below.

Freedom of Choice Waiver — The Act provides that the Secretary of Health and Human Services (HHS) will be permitted to waive freedom of choice requirements under specified circumstances. States may implement case management or specialty physician arrangements, provided that Medicaid requirements are met. Beneficiaries of Medicare and Medicaid funds can be restricted to a single primary care physician if those services meet medical necessity requirements. When the "locality" adopts the single provider method or acts as central broker for choice of health care services, resultant cost savings must be returned to beneficiaries through additional services.

Under another provision of the Act, states may restrict freedom of choice to those providers who meet specified quality and utilization standards. These waivers, which can be renewed, may stand for two years.

The Act also permits states (and their political subdivisions) to purchase laboratory services and medical devices through competitive bidding. Eligible laboratories must meet specified health and safety requirements and bill no more than 75% of the charges to Medicare or Medicaid.

States may also restrict beneficiaries who have been found to utilize services beyond medical necessity to specific providers. Similarly, providers who furnish goods or services beyond medical necessity or beneath quality standards may be suspended from the program.

In another area, Medicaid payments under state plans need no longer adhere to the "reasonable charge" levels established under Medicare, but are limited only by "efficiency, economy and quality of care."

The Act eliminates federal matching payments for non-emergency inpatient hospital tests which are not ordered by the attending physician or "other responsible practitioner."

PSRO performance assessment will also be affected by the budget bill. Performance assessment is to be conducted under requirements to be established by HHS. Benchmarks are designated as quality of care monitors, reduction of excessive utilization and management efficiency. These criteria will assist HHS in terminating up to 30% of established PSROs by May, 1981. The Secretary need not grant a formal hearing for terminated PSROs. In another change under the Act, the Secretary may no longer require review of ancillary, ambulatory and long term care services — but may require *focused* review for conditionally designated PSROs.

ISMS will be reviewing impact of the Omnibus Reconciliation Act on Illinois physicians. Analyses will be published in upcoming issues of Action Report and *IMJ.*

ERRATA — The editor of the *IMJ* Viewbox column, Terrence Demos, M.D., and the contributing author for the July issue, Michael Fine, M.D., have asked that the following information be published to clarify statements in that column, on page 14 of that issue:

In the Viewbox of the July issue, a patient with a herniated lumbar disc was presented. The disc caused only equivocal abnormality on a metrizamide myelogram but was clearly demonstrated by computed tomography.

The patient's history was given as pain and sensory loss in the S_2 nerve root distribution. It should have read *back* pain.

Computed tomography has proven to be an important means of diagnosing lumbar disc disease. It should be emphasized, however, that not all C.T. machines can provide diagnostic information. The machine must be capable of high spatial and contrast resolution which includes ability to take thin (2 to 5 mm) slices. Angulation of the gantry to the angle of the disc has been used in order to provide more precise evaluation of tissue relationships, but is not used in all institutions.

FALL SEMINAR ANNOUNCED — The ISMS Medical Student Section annual fall seminar will be held Thursday, October 15, at 7:30 p.m., Loyola Medical Center, Maywood. Topics will include medical economics — with special attention given hospital costs and inflation — and alternative health practices. Flyers publicizing the seminar will be sent to each medical school for dissemination. Additional information may be obtained by calling the ISMS offices at (312) 782-1654.

PM&R MEETING ANNOUNCED — The 1981 Tri-State Scientific Meeting of the Societies of Physical Medicine and Rehabilitation is scheduled for Saturday, September 26, University of Health Sciences/Chicago Medical School, North Chicago campus. Further information may be obtained by contacting Eugene J. Rogers, M.D., professor and chairman, Department of Rehabilitation Medicine, UHS/CMS, 3333 Green Bay Road, North Chicago IL 60064; (312) 539-4671.

GEARING UP FOR RETIREMENT will be the topic of an AMA practice management workshop on October 2, repeated October 28 and December 4, at the AMA Chicago offices. The workshops are to focus on appraising post-retirement opportunities in employment and recreation, finances in the event of death or disability, financial management after retirement and family life adjustments. Estate and tax planning presentations will be included. Further information may be obtained by contacting Kimberlee Watts, AMA, 535 N. Dearborn, Chicago 60610; (312) 751-6383.

CRITICAL ISSUES IN HEALTH LAW is the title of a November 19 - 20 conference sponsored by the American Society of Law and Medicine. The conference, which will be held in the Washington Hilton Hotel, Washington, D.C., will feature presentations on regulation, allied health professionals, labor law, product liability, terminal illness, abortion and related issues and medical staff privileges. Registration for ASLM members is $160 before September 30 and $180 thereafter. Non-member registrants will pay a $20 surcharge. Further information may be obtained through A. Edward Doudeara, J.D., Executive Director, American Society of Law and Medicine, 520 Commonwealth Avenue, Boston MA 02215; (617) 262-4992.

Blue Cross® Blue Shield®

REPORT FOR Illinois Physicians

Health Care Symposium Scheduled October 30th

An all-star line-up of speakers has been assembled for the Illinois Blue Cross and Blue Shield Plan's sixth annual health care symposium to be held Friday, October 30, at the Hyatt Regency Chicago Hotel.

Among the participants scheduled for the day-long program, entitled "The Organization and Management of the Health Care System in the 1980s," are Speaker of the House Thomas "Tip" O'Neill; Rep. Dan Rostenkowski, chairman of the House Ways and Means Committee; Virginia Knauer, director of the U.S. Office of Consumer Affairs; Arthur B. Laffer, a leading economic advisor to the Reagan Administration, and Lloyd McBride, president of the United Steelworkers of America.

Also scheduled are Mrs. Coretta King, president of the Martin Luther King, Jr., Center for Non-Violent Social Change, who will be the luncheon speaker; Charles Schultze, former chairman of the Council of Economic Advisors; Alvin Tarlov, M.D., professor of Medicine at the University of Chicago Hospitals and Clinics and Edward J. Connors, president of the Sisters of Mercy Health Corp.

The symposium is scheduled to begin at 8:30 a.m. and conclude at approximately 3:30 p.m. Registration fee is $50.00. For further information, please contact Gus Rose at (312) 661-4484.

Free Standing Ambulatory Surgical Facilities Supported

The Illinois Blue Cross and Blue Shield Plan has been a proponent of Free Standing Ambulatory Surgical Facilities since enabling legislation was enacted more than six years ago. The Plan feel facilities of this type provide a means of controlling health care costs without sacrificing patient needs.

There are now seven such facilities which have been approved for Plan affiliation and are in operation. They are: Northwest Surgicare in Arlington Heights; Hugar Surgery Center in Elmwood Park; Mercy Health Care Center in Justice, formerly the Forest Hills Surgical Center; Hinsdale Surgical Center in Hinsdale; Notre Dame Hills in Belleville, Surgicare Center in Chicago Heights, and Albany Women's Medical Center in Chicago.

The Plan's policy, prior to enactment of the legislation, was that ambulatory surgery should take place within licensed hospitals, with hospitals making special arrangements to facilitate the care of these patients.

As hospitals began to expand their surgical programs to include procedures that could be performed safely on an ambulatory basis, the Plan encouraged the development of these programs.

Each new free standing facility approved by the Plan has a contract that includes a Procedure List and Charge Schedule for surgery and operating room services, necessary test and x-rays.

Blue Cross and Blue Shield members having surgery performed at any of the free standing facilities are eligible to receive outpatient surgical benefits in accordance with provisions of benefit programs.

A free standing ambulatory surgical facility wishing to affiliate with Health Care Service Corporation as a member facility should submit evidence that the facility and its staff does and will comply with prescribed minimum standards and agrees to periodic evaluation by Health Care Service Corporation to confirm continued compliance. The Provider Affairs Department should be contacted for further information.

Psychotherapy Benefits Detailed for Federal Employee Program (FEP)

Following is an expanded explanation of the Federal Employees benefits for psychotherapy:

Blue Shield Basic Benefits

In hospital psychotherapy is a benefit when rendered during a hospital admission, or part of an admission covered by Basic Hospital Benefits.

High Option Pays

100 percent of usual and customary charges (U&C).

Low Option Pays

Amounts set by fee schedule. Any balance may be eligible for Supplemental Benefits (up to U&C).

Supplemental Benefits For Outpatient Psychotherapy

Each claim for services of a physician, clinical psychologist, psychiatric social worker, or psychiatric nurse must show the type and length of each therapy session. For services of a psychiatric social worker, or psychiatric nurse, each claim must be accompanied by a certification form available from the local plan and completed by the attending physician (M.D.) showing that services were performed at the direction and under the supervision of the attending physician (M.D.).

Covered Services

Day-night hospital services. Therapy (individual or group) not exceeding two hours per day, and collateral visits with members of the patient's immediate family, provided by a physician, clinical psychologist, psychiatric nurse, or psychiatric social worker.

Psychological Testing

Services rendered by a psychiatric nurse, or psychiatric social worker, are covered only if:

A physician (M.D.) requested the services and referred the patient, and the care rendered was under the supervision and direction of a physician (M.D.) who saw the patient or had written or personal consultation with the psychiatric nurse or psychiatric social worker at least once every 90 days during the course of treatment, and the supervising physician (M.D.) saw the patient at least once every 12 months during the course of treatment.

Services not Covered

Marital, family, or other counseling or training services. Services rendered or billed for by a school or halfway house or a member of its staff.

Psychoanalysis or psychotherapy credited toward earning a degree, or furtherance of the education or training of a subscriber, regardless of diagnosis or symptoms that may be present.

Bio-feedback and other forms of selfcare or self help training and related diagnostic testing.

High Option Pays

70 percent of U&C after patient meets annual $150.00 deductible.

Low Option Pays

60 percent of U&C after patient meets annual $200.00 deductible.

$50,000 lifetime maximum per person for the treatment of mental illness.

Certain Zenith Groups Get 100 Percent U&C

Zenith personnel in groups #80006, #80067, #80076 and #80077 now have 100 percent U&C coverage for physicians' services in the following areas:

- Surgery
- In-hospital medical care*
- Anesthesia
- X-ray and laboratory tests rendered in clinics or physician's office
- Pathological services
- Surgical Assistant (when necessary)
- Medical emergency services

*Note: In-hospital medical care for psychiatric, drug and alcohol abuse is covered at 80 percent U&C.

How To Return A Blue Shield Payment

When it is necessary to return a Blue Shield check or send a refund by personal check, the following information should be included.

A. **Return of a Blue Shield Check:**
 (1) Attach the voucher portion of the check, if possible.
 (2) If the voucher cannot be attached, include:
 (a) Patient's Blue Shield group and subscriber number;
 (b) Blue Shield case number;
 (c) Date of service;
 (d) Blue Shield check number.
 (3) A brief explanation for returning an incorrect payment.

B. **Refund by Personal Check:**
 (1) Make the check payable to Health Care Service Corporation.
 (2) Include:
 (a) A brief explanation for the refund;
 (b) Name of the patient;
 (c) The patient's Blue Shield group and subscriber number;
 (d) Date of service.

All checks should be mailed to Blue Shield, 233 North Michigan Avenue, Chicago, Illinois 60601.

Your cooperation is appreciated.

IMJ

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Fred Z. White, M.D., President

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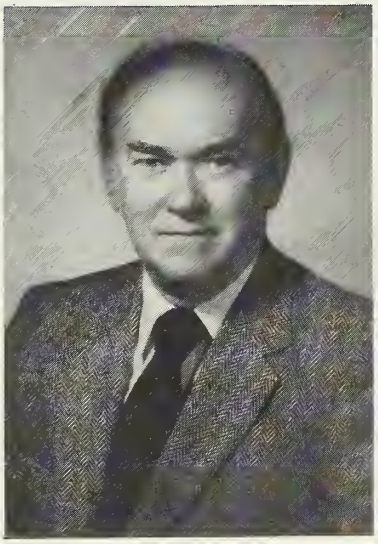
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President's Page

Genesis



In the beginning, there was the physician and the patient. The patient trusted the physician's judgment and his medical decision making. The physician held that trust as a sacred stewardship and made those medical judgments on the basis of necessity and the best medical interests of that patient.

That physician-patient relationship changed and new relationships began to evolve when others began to pay for the patient's medical bills. This third party in the triangular relationship did not trust the judgment of the physician. Instead, means of certifying medical necessity were developed. These certifying methods range from approval of hospital staff membership to audits of physician activity. This represented a means of validating the judgment of the physician as to what is necessary and appropriate in patient care.

We as physicians realize that the responsibility for making medical judgments is ours and ours alone. This is a heavy responsibility, but one which we must accept. As the pressure of cost containment forces medical care to move from traditional hospital settings to ambulatory surgery services, outpatient areas of the hospital, and—in the case of some procedures—back to the offices of the physician, the usual certifying mechanisms (hospital admission, hospital UR committee, etc.) will not be available to the third party carriers.

Ultimately, the day may come when it will be enough for the physician to say to the insurance carrier, "This is necessary." However, until that day occurs, carriers will require some sort of validation or certification.

This should and must be done by physicians at the most local level, through physician-designed and sponsored review organizations.

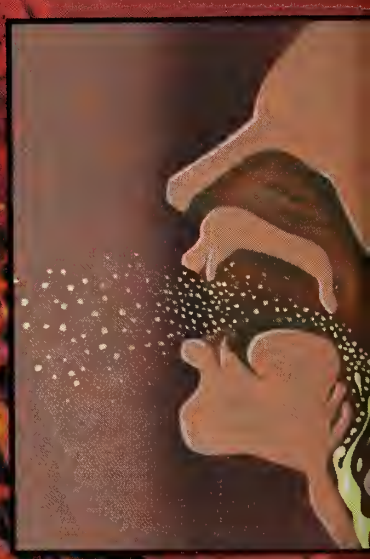
There is, therefore, a most cogent need for physician review organizations, including extension beyond the hospital UR committee. These review organizations also should remain as close as possible to the heart and mind of medicine.

This issue certainly deserves our consideration not only as individual physicians, but also as a society. We must assume responsibility in this area—especially as more patient care returns to the ambulatory and office setting. ◀

Fred Z. White, M.D., President

Signs of an acute exacerbation of chronic bronchitis*

Cough



* Due to susceptible strains of *H. influenzae* or *S. pneumoniae*

color, quantity

Reducing cough severity, clearing sputum purulence and lessening sputum production are important goals of antimicrobial therapy in acute exacerbations of chronic bronchitis. Bactrim DS can usually achieve those goals.

Efficacy unexcelled by ampicillin *q.i.d.* In three double-blind comparisons,[1-3] Bactrim DS *b.i.d.* proved at least as effective as ampicillin *q.i.d.* Also, the development of *in vitro* resistance to Bactrim by strains of *H. influenzae* and *S. pneumoniae*—the two primary pathogens in acute exacerbations of bronchitis—is rare.



Efficacy superior to tetracyclines. In 10 clinical comparisons involving nearly 700 patients, Bactrim consistently produced superior levels of improvement, judged by such parameters as clinical assessment, change in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens.[4] (In two studies, tetracyclines resulted in a lower incidence of mucoid sputum 4 weeks posttherapy.)[4] Even though some of the studies employed higher daily dosages of Bactrim than recommended, the incidence of G.I. discomfort was lower with Bactrim (7%) than with tetracyclines (12%) (see adverse reactions in summary of product information).

And...its *b.i.d.* dosage makes Bactrim DS an even more attractive choice because it encourages patient compliance. During therapy maintain adequate fluid intake. Use cautiously in patients with impaired renal or hepatic function, severe allergy or bronchial asthma.

Clears the sputum, lowers the volume... with B.I.D. convenience

Bactrim™ DS

160 mg trimethoprim and 800 mg sulfamethoxazole

ROCHE®

Please see next page for references and a summary of product information.
Contraindicated in pregnancy, lactation, infants under two months, and patients hypersensitive to either component.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole)

Refarancas: 1. Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts*. Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 15-16. **2.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **3.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **4.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

Bafora prascribing, pleasa consult complata product information, a summary of which follows:

Indications and Usaga: For tha traatment of *u*rinary tract infections dua to suscaptible strains of the following organisms: *Escherichia coli, Klebsiella-Entarobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommandad that initial apisodes of *u*ncomplicatad urinary tract infactions ba traatad with a singla effectiva antibactarial agant rathar than tha combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For *s*cute otitis madia in childran dua to suscaptibla strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* whan in physician's judgment it offars an advantaga ovar othar antimicrobials. Limitad clinical information prasantly availabla on affactivanass of traatmant of otitis madia with Bactrim whan infaction is dua to ampicillin-rasistant *Haemophilus influenzae*. To data, thara are limitad data on tha safaty of repaatad usa of Bactrim in childran *u*ndar two yaars of age. Bactrim is not indicatad for prophylactic or prolongad administration in otitis madia at any aga.

For acute exacarbstions of chronic bronchitis in adults dua to *s*uscaptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offars an advantaga ovar a singla antimicrobial agant.

For antaritis dua to suscaptible strains o‹ *Shigella flexneri* and *Shigella sonnei* whan antibacterial therapy is indicatad.

Also for tha trastmant of documantad *Pneumocystis carinii* pneumonitis. To data, this drug has baan tastad only in patiants 9 months to 16 yaars of aga who wara immunosupprassad by csncar tharspy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dossga: Not racommended for infants lass than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Clinics for Crippled Children Listed for November

Forty-three clinics for Illinois' physically handicapped children have been scheduled for November by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 29 general clinics, 11 cardiac clinics, one for children with neurological problems and two for children with myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

2 Peoria Myelodysplasia - St. Francis Medical Center
3 Park Ridge Cardiac - AM - Lutheran General Hospital
3 Park Ridge General - PM - Lutheran General Hospital
3 Wheaton General - Marianjoy Rehab. Hosp.
4 Cairo - Southern Seven Health Department
4 Hinsdale - Hinsdale Sanitarium
5 Sterling - Community General Hospital
5 Effingham - St. Anthony Mem. Hospital
5 Lake County Cardiac - Victory Mem. Hosp.
6 Division Cardiac - U. of I. at the Medical Center
9 Peoria Cardiac - St. Francis Med. Center
9 Chicago Heights Cardiac - St. James Hosp.
9 Maywood - (Orth/Ped/Neuro) - Loyola Medical Center
10 East St. Louis - Community Hospital
10 DuQuoin - Marshall Browning Hospital
10 Peoria - St. Francis Medical Center
11 Rockford - St. Anthony Hospital
11 Champaign-Urbana - McKinley Health Service Center
11 Chicago Heights General - St. James Hosp.
11 Joliet - St. Joseph's Hospital
11 Aurora MM - Mercy Center for Health Care Services
12 Pittsfield - Illini Community Hospital
12 Macomb - McDonough Health Department
12 Kankakee General - St. Mary's Hospital
12 Aurora Cardiac - Mercy Center for Health Care Services
16 Maywood - (Orth/Ped) - Loyola Medical Ctr.
17 Rock Island General - Moline Public Hosp.
17 Alton - Alton Memorial Hospital
17 Decatur - Decatur Memorial Hospital
18 Springfield Ped-Neuro - St. John's Hospital
18 Elgin General - Sherman Hospital
18 Evergreen Park - Little Company of Mary Hospital
19 Springfield General - St. John's Hospital
19 Centralia - St. Mary's Hospital
19 Elmhurst Cardiac-Memorial Hospital of DuPage County
20 Kankakee Cardiac - St. Mary Hospital
23 Peoria Cardiac - St. Francis Med. Center
23 Maywood - (Orth) - Loyola Medical Center
23 Chicago Heights Cardiac - St. James Hosp.
24 Peoria - St. Francis Medical Center
24 Belleville - St. Elizabeth's Hospital
25 Chicago Heights General - St. James Hosp.
30 Peoria Cardiac - St. Francis Medical Ctr.

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

Abstracts of Action

June 27, 1981

Marriott O'Hare
Rosemont

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

CONFIRM PLANS FOR INTERIM MEETING OF HOUSE, NOV. 7-8

The Board of Trustees confirmed plans for an Interim Meeting of the ISMS House of Delegates, Nov. 7-8, in Springfield. A leadership conference will be held in conjunction with the meeting. Although directed at county medical society officers and members of the House and Board, the conference will be open to the general membership. It will consist of: (1) A negotiating training seminar; (2) Symposium on allied health practitioners; (3) Slide presentation on HMOs and IPAs; and (4) Addresses by key legislators and State department directors.

The Board will re-examine the annual and interim meetings in terms of their length, content, cost and location . . . and consider the feasibility of holding one of the meetings in Springfield each year while the Illinois General Assembly is in session.

PSRO REPLACEMENT/COST CONTAINMENT

Responding to federal cutback of the PSRO program, the Board voted to develop a program to replace review functions of PSROs and related issues. An ad hoc committee consisting of the Chairman of the Board, President, President-Elect, First Vice President, Secretary-Treasurer and Speaker of the House will study the issue and submit recommendations to the Board. A position paper will be developed for consideration of the House of Delegates at its interim meeting. Informational sessions for the general membership will be conducted at the district level this fall, and a special program will be presented to the House of Delegates.

Meanwhile, Illinois Department of Insurance Director Philip O'Connor told ISMS officers that the cost containment initiatives he proposed as part of a rate hike granted recently to Blue Cross/ Blue Shield were not intended as "final policy directives." He said that they were only suggestions subject to modification by the department. ISMS input would be welcomed, he said.

BOARD SUPPORTS DR. JIRKA'S CANDIDACY FOR AMA PRESIDENT-ELECT

The Board unanimously voted to vigorously support the candidacy of *Dr. Frank J. Jirka* for president-elect of the AMA. The Board recognized Dr. Jirka's demonstrated record of achievement as a leader of organized medicine. Dr. Jirka has been a member of the AMA Board of Trustees, and has served as the Board's secretary, secretary-treasurer and vice-chairman. He also served as trustee, board chairman and president of ISMS, president of the CMS Douglas Park Branch and a CMS councilor and delegate to ISMS.

(Continued on page 251)

"I Quit" Clinics

The Illinois Interagency Council on Smoking and Disease has facilitated a series of "I Quit Smoking" clinics around the state. The clinics are held for five days in 1½ hour sessions.

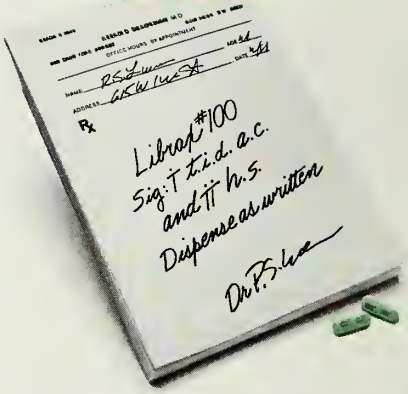
Inquiries should be addressed to the Council at 20 N. Wacker Drive, Room 1240, Chicago 60606. Telephone (312) 346-4675.

The Illinois Interagency Council on Smoking and Disease coordinates and helps its member agencies combat the serious health hazards of smoking and provides liaison with the National Interagency Council on Smoking and Health.

The *Journal* will carry this listing on a regular basis, and urges Illinois physicians to notify their patients of this service.

November 3	Copley Memorial Hospital	Aurora
November 9	Roekford YWCA & Northern Illinois Interagency Counell on Smoking	Rockford
November 10	Copley Memorial Hospital & A.C.S.	Aurora
November 16	St. Therese Area Trauma Satellite	Lake Villa
November 17	Merey Hospital & A.C.S.	Chicago
January 4	Resurrection Hospital & A.C.S.	Chicago
January 6	Highland Park Hospital & A.C.S.	Highland Park
January 11	Condell Memorial Hospital & A.C.S.	Libertyville

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

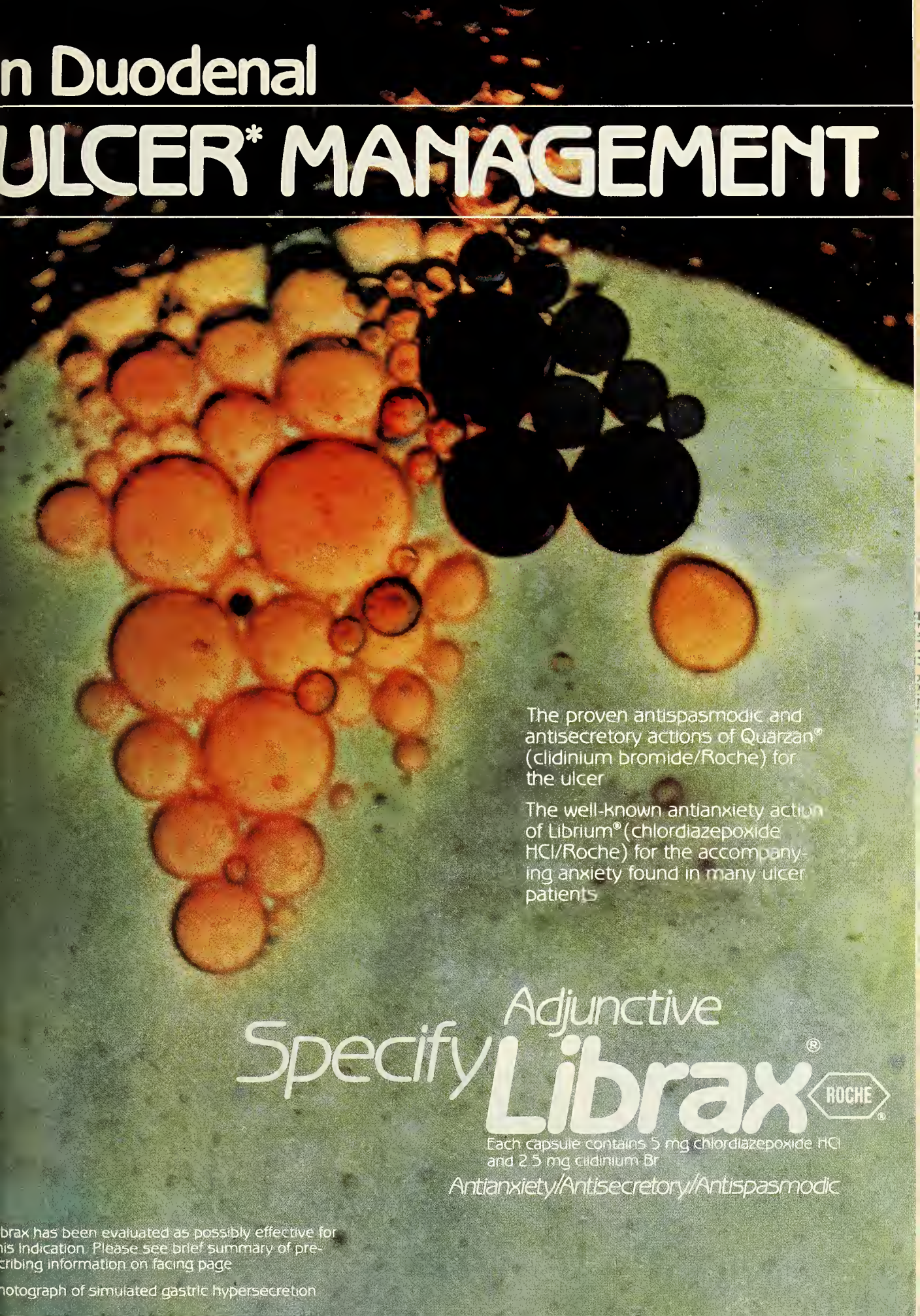
As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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brax has been evaluated as possibly effective for
his indication. Please see brief summary of pre-
cribing information on facing page

hotograph of simulated gastric hypersecretion

The Viewbox

Contributing Editor Terrence Demas, M.D., associate professor of radiology,
Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was contributed by Edward Chesna, M.D., Department of Radiology, Loyola University Medical Center, Maywood.

These three neonates have distended abdomens and have not passed meconium at 48 hours.



Figure 1
Patient 1: Barium Enema

Match each patient with a diagnosis:

1. Hirschsprung's Disease
2. Normal
3. Meconium plug syndrome
4. Anorectal anomaly
5. Stricture due to necrotizing enterocolitis.



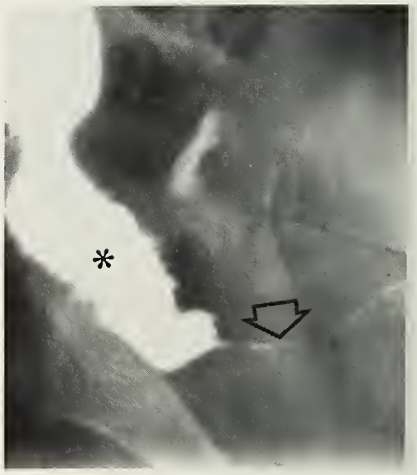


Figure 2 A **Figure 2 B**
Patient 2: Plain film and injection of contrast into urethra (arrow) which results in filling of colon (asterisk)





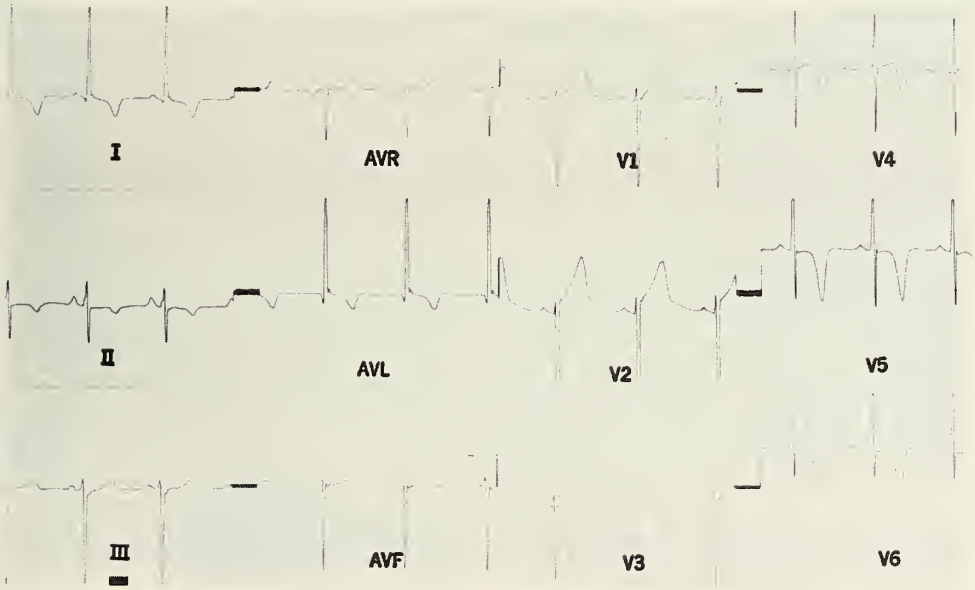
Figure 3A **Figure 3 B**
Patient 3: Two films from a barium enema. (Sigmoid marked by arrows.)

(Continued on page 265)

EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a fifty-seven year old black man who complained of headaches and chest pains. His headaches were present in the morning and disappeared as the day progressed. The chest pains were located in the middle of his chest, felt like a cramp, and occurred with heavy work. The chest pains were always relieved by rest and didn't concern the patient as much as his headaches. Physical examination showed a husky, healthy man with a blood pressure of 190/120. All pulses were equal. His pulmonary exam was normal and a loud atrial gallop was heard on examination of the heart. A twelve lead ECG was taken as part of the work-up and is shown.



Questions:

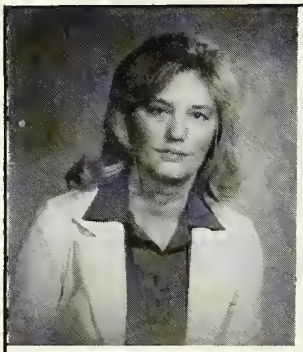
1. The ECG shows:

A. Severe right ventricular hypertrophy.
B. Left bundle branch block.
C. Severe left ventricular hypertrophy.
D. Left axis deviation.
E. Unusual right axis deviation.

2. The cardiac lesions that can be associated with this ECG abnormality is/are:

A. Idiopathic hypertrophic subaortic stenosis.
B. Calcific aortic stenosis.
C. Hypertension.
D. Severe aortic regurgitation.
E. All of the above.

(Continued on page 258)



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IMJ
Illinois Medical Journal
Volume 160, No. 4, October 1981

Use of CT to Uncover Underlying Brain Tumor

Trigeminal Neuralgia

By Philip B. Gorelick, M.D. And Joseph C. Masdeu, M.D.
Hines And Maywood

Three cases originally diagnosed as primary trigeminal neuralgia are reviewed. Subsequent investigations revealed underlying tumor pathology of the cerebellopontine angle. The importance of careful clinical follow up and the diagnostic usefulness of computerized tomography (CT) in facial pain patients are underscored.

It is estimated that tic douloureux is newly diagnosed in 15,000 Americans each year.[1] These patients present with intense, paroxysmal pain in the trigeminal nerve distribution with trigger areas on the face and a normal neurological examination.[2] In five percent of these cases, a tumor near the trigeminal nerve is responsible for the pain.[3] Prior to the development of pneumoencephalography and high radiodensity contrast studies, these lesions were once diagnosed by surgical exploration.[4] With the advent of computerized tomography (CT), small lesions in or near the cerebellopontine angle presenting as facial pain can be easily detected by a non-invasive procedure, allowing early removal. This communication will review three such cases exemplifying the three most common tumor types. In all the diagnosis of primary trigeminal neuralgia was made several months prior to admission.



JOSEPH C. MASDEU, M.D., is a board certified neurologist affiliated with the Loyola University Stritch School of Medicine. An assistant professor in the department of neurology at Loyola, Dr. Masdeu is also assistant chief of the neurology service at Hines Veterans Administration Hospital.

PHILIP B. GORELICK, M.D., is a neurology resident at the Hines Veterans Administration Hospital and Foster G. McGaw Memorial Hospital, Maywood. Dr. Gorelick is a graduate of the Loyola University Stritch School of Medicine.

Report of Cases

Case 1. A 49-year-old mailman was admitted with a four month history of left facial pain. It was paroxysmal and shooting in character with radiation down the mandible from the preauricular region. Initially it lasted several seconds but over ensuing months became more frequent and severe. Shaving, combing, and eventually jaw movement triggered the pain. At the onset of this illness a diagnosis of trigeminal neuralgia was made. Partial relief was obtained from a combination of carbamazepine (1200mg/day) and diphenylhydantoin (300mg/day).

On physical examination, periodic left facial grimacing was noted. The neurological examination, including audiometry, was normal. Electrophysiological testing disclosed depression of the left masseter reflex. X-ray views of the skull,

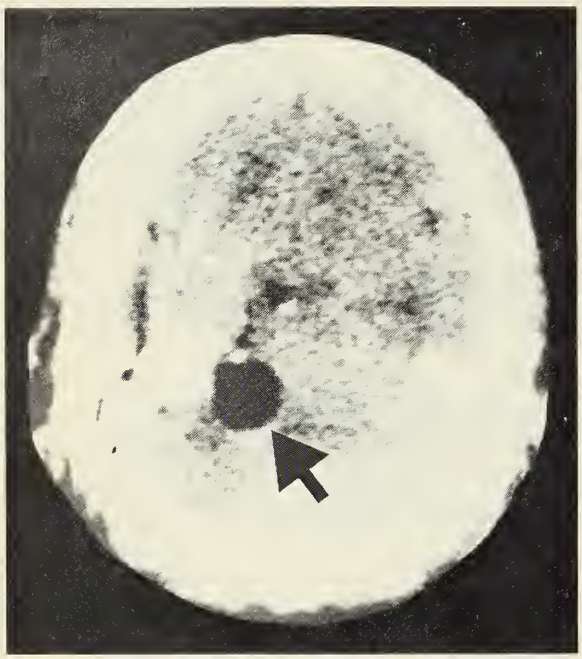


Figure 1
CT scan of Case 1 showing a rounded lesion of low radiodensity by the tip of the left petrous bone. An epidermoid tumor was removed at surgery.

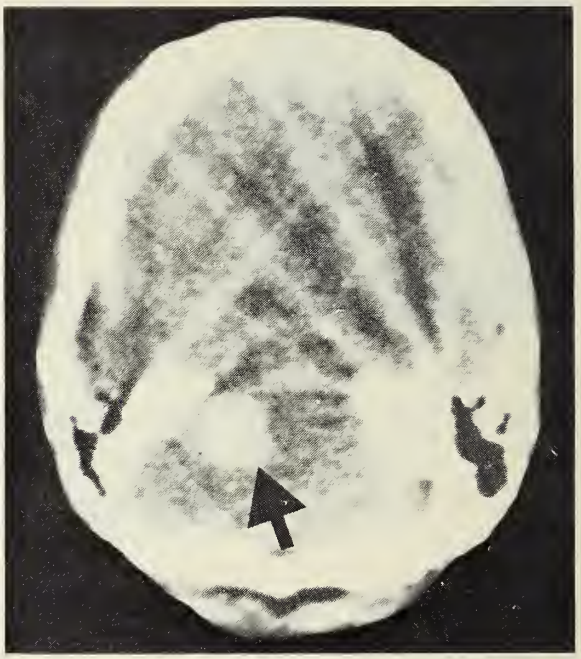


Figure 2
Post-contrast influsion CT scan of Case 2, showing an acoustic neurinoma by the tip of the left petrous bone. In spite of the linear artifacts related to motion, the lesion is well visualized.

temporomandibular joints, and internal auditory canal tomograms were normal. CT scanning revealed a well circumscribed left cerebellopontine angle lucency with a small area of calcification in the upper pole (Figure 1). Angiography demonstrated displacement of the left anterior inferior cerebellar artery towards the midline and posteriorly. The pain disappeared after removal of an epidermoid tumor.

Case 2. A 31-year-old carpenter was admitted with concomitant headache and facial pain for one and a half years. The headache was located in the left orbital region and throbbed. It was associated with a twinging pain of the left upper lip that was triggered by lower facial movements. In the three to four month period, attacks lasted 10-15 seconds and occurred several times a day. Several months of pain free intervals were then followed by attacks of increasing frequency and duration. No hearing loss was noted. Early in the course a physician diagnosed tic douloureux while a second examiner diagnosed cluster headache as associated lacrimation, rhinorhea, and nasal congestion were described by the patient. Neurological examination six months prior to admission was reported to be normal.

At the time of admission he had a diminished left corneal reflex, diminished pin sensation in the maxillary distribution of the left fifth cranial nerve, left sided sensorineural hearing loss, and mild left peripheral facial weakness. Skull series was read as normal, while tomograms of the internal auditory canal demonstrated left-sided widening of the porus acusticus and petrous bone erosion. A hearing test revealed moderate sensorineural loss in the range of 4000-8000Hz in the left ear with excellent speech discrimination and absence of tone decay. An electronystagmogram demonstrated the absence of vestibular reaction to stimuli in the left ear. The blink and masseter reflexes were depressed on the left side. CT scanning disclosed a left cerebellopontine angle mass which enchanced uniformly upon contrast injection (Figure 2). Angiography showed upward displacement of the anterior inferior cerebellar artery. Craniotomy exposed an acoustic neurinoma displacing the facial nerve forward and the trigeminal nerve upward. Postoperatively the patient remained pain free without medication.

Case 3. A 55-year-old machinist complained of intense, intermittent facial pain in the left mandible for eight years. He had been examined by several neurologists over this period, and all had reached a diagnosis of trigeminal neuralgia. Trials of carbamazepine and diphenyl-hydantoin were terminated as transient drug-induced ataxia occured.

The patient was scheduled for a neurosurgical procedure to relieve the pain. On admission, a

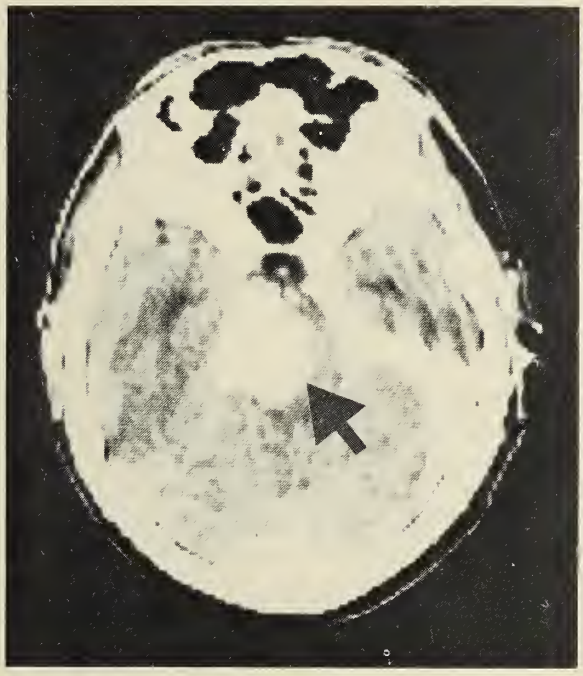


Figure 3
Post-contrast infusion CT scan of Case 3, showing a left petrous ridge meningioma.

history of vertigo, difficulty with balance, and hearing loss was obtained while physical examination remained normal. This prompted radiological evaluation which included normal tomograms of the internal auditory canal; a CT scan revealing a uniformly enhancing left cerebellopontine angle mass which was partially calcified and extended medially compressing the pons (Figure 3). Posterior fossa angiography demonstrated upward displacement of the left posterior cerebral artery and medial displacement of the left superior cerebellar artery. After a petrous ridge meningioma was removed, the facial pain subsided.

Comment

Trigeminal neuralgia is occasionally the presenting symptom of cerebellopontine angle tumors.[3] Acoustic neurinomas head the list in most series and may present without hearing loss. Meningiomas, cholesteatomas, chordomas, and arteriovenous malformations are encountered in these patients.[3,8]

Patients presenting with facial pain can be grouped into those with isolated pain and those with pain as a part of a more complex clinical picture. This second group of patients has, in addition to sensory trigeminal involvement, signs and symptoms of adjacent cranial nerve dysfunction. Therefore, when evaluating facial pain patients, special emphasis should be placed on historical information suggesting tinnitus, hearing or vestibular dysfunction, and facial numbness or asymmetry. The presence of any one of these complaints, or of any abnormalities of the fifth through ninth cranial nerves on examination, would prompt the clinician to search for a mass compressing the trigeminal nerve.[3,5,6] As noted in case one, a mild neurological deficit may be overlooked and may not become apparent until an electrodiagnostic study is carried out.[7]

Management of patients with facial pain characteristic of trigeminal neuralgia and a normal neurological examination is more challenging. This syndrome is benign in a large number of cases, and yet each year about 700 Americans present in this manner and are later found to harbor a tumor.[1,3] For these patients an ancillary diagnostic schedule is required to ensure proper diagnosis. In those locations where CT is readily available, a selective scan of the middle and posterior fossa is advised for patients presenting with recent onset tic douloureux. As exemplified by our cases, conventional X-ray studies may be normal, or read as normal because changes are few, while a tumor is easily seen on CT. In those areas where availability or cost of scanning is prohibitive, a second diagnostic approach is taken. If the neurological examination is normal, skull X-rays, with careful evaluation of the petrous bone and basal foramina and audiometry are recommended. Referral for CT or contrast study is advised if a pertinent abnormality is found on either test. If skull X-rays and audiometry are normal, the patient is followed clinically for the appearance of symptoms suggesting an enlarging mass. In this event, CT is indicated regardless of normal audiometric and skull X-ray studies.

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Small Bowel Metastases In Bronchogenic Carcinoma

By Helen Wiedemer, M.D., Mukund Godbole, M.D., And Samuel K. Appavu, M.D., F.A.C.S./Chicago

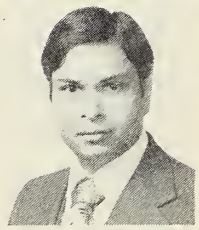
The occurence of symptomatic small bowel metastases is rare. Two cases of small bowel metastases arising from bronchogenic primary tumors are described; one with obstruction and one with perforation. The rapid growth associated with anaplastic tumors may lead to luminal obstruction, intussusception, or necrosis with subsequent perforation. Small bowel metastases should be considered whenever a patient with a previous malignacy develops symptoms of obstruction or intestinal perforation.

Bronchogenic carcinoma gives rise to widespread hematogenous metastases which may be diagnosed even before the primary tumor is discovered. Distant metastases most commonly are found in the liver, adrenal glands, bones and brain.[1,2] Symptomatic metastases to the small bowel are unusual. We present two cases of small bowel metastases of surgical significance, one with obstruction and one with perforation, to emphasize that this problem can occur and may require surgical intervention.

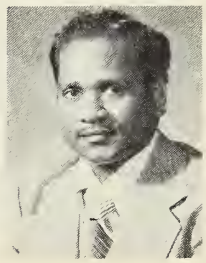
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Case 1

A 59-year-old black male smoker presented with left-sided chest pain, hemoptysis, and a 10kg. weight loss. Physical examination revealed decreased breath sounds over the left chest and pulmonary osteoarthropathy. Roentgenograms of the chest showed a 12cm left upper lobe lung mass. Sputum cytology and bronchoscopic biopsy were not diagnostic. Work up for distant metastasis was negative.

A limited laparotomy that was performed prior to thoracotomy revealed the liver and peritoneum to be free of tumor. A left pneumonectomy was then performed. The pathologic diagnosis was undifferentiated large cell adenocarcinoma with sarcomatous foci with areas of intravascular invasion. The patient received 4500 rads postoperatively to the left chest and mediastinum.

Ten weeks later, the patient returned to the hospital with clinical and radiological signs of small bowel obstruction. At laparotomy, an obstructing tumor mass was found in the mid-jejunum, with two smaller non-obstructing masses in close approximation. Resection of the involved small bowel and end-to-end anastamosis were performed.

On examining the specimens, (Figures 1 and



Figure 1
Typical appearance of a hematogenous small bowel metastasis showing a sessile mass with a flared, scalloped margin and central umbilication.



Figure 2
Full-thickness replacement of the bowel wall is shown. Necrosis of the tumor could result in a perforation.

2) it was noted that all three tumor nodules replaced the full-thickness of the bowel wall and were located on the anti-mesenteric border. Each nodule was oval with scalloped margins and a central umbilication. Microscopic examination showed anaplastic pleomorphic features similar to the sarcomatous foci of the primary lung tumor.

Case 2

A 52-year-old male smoker presented with chronic cough. Physical examination was unremarkable. A roentgenogram of the chest revealed a large mass in the upper lobe of the right lung. The presumptive diagnosis was carcinoma. The patient refused diagnostic work-up and treatment. Nine months later, he returned with left hemiparesis and left-sided sensory deficit. A space-occupying lesion of the right cerebral hemisphere was demonstrated by computerized axial tomography. A percutaneous needle biopsy of the lung mass showed giant cell anaplastic carcinoma.

During the same hospitalization, the patient developed sudden severe abdominal pain and physical findings consistent with peritonitis. Abdominal roentgenograms showed free air under both hemidiaphragms. At laparotomy, a metastatic tumor nodule with perforation was found in the proximal jejunum. Resection of the small bowel segment with end-to-end anastamosis was performed. Microscopic examination of this nodule was compatible with metastatic anaplastic carcinoma from the primary lung tumor.

Discussion

Malignant lesions may spread by direct extension, transperitoneal seeding, permeation of the lymphatic spaces and implantation and growth of vascular or lymphatic emboli. Bowel obstruction from visceral involvement in far advanced carcinomatosis is all too familiar. The occurrence of blood-borne metastatic nodules affecting the small bowel alone is rare. Metastatic tumors to the small bowel become clinically significant by the production of obstruction or perforation.

Willis, is his 500 necropsies on patients with malignant lesions, found 10 cases of blood-borne small bowel metastases. One case arose from a primary carcinoma of the lung. He emphasizes that blood-borne metastases are generally flat, subserosal nodules with lateral spread as seen in case one. Pedunculated lesions may project into the lumen and serve as a lead point for intussusception.[2,3]

DeCastro, *et al,* reviewed 101 cases of small bowel obstruction associated with metastatic malignancy at the Mayo Clinic between 1905-1954. Only 25 cases were due to discrete blood-borne metastasis. None of these cases were associated with a primary bronchogenic tumor.[4] In Das Gupta's series of metastastic melanomas to the gastrointestinal tract, an intussucepting small bowel metastasis was the most common finding in patients presenting with symptoms of small bowel obstruction.

Six cases of perforation of the small bowel subsequent to metastasis from bronchogenic carcinoma have been reported.[5-10] Perforation is due to necrosis of the metastatic nodule and may be associated with chemotherapy or radiation.[7] Necrotic tumor may be passed per rectum.[2]

Histologically high grade primary tumors predominate in causing symptomatic small bowel metastases. At least five of the six previously reported perforations subsequent to small bowel metastases arose from an anaplastic bronchogenic carcinoma.[9] In both of our cases, the primary tumor showed anaplasia. Rapid tumor growth in anaplastic lesions contributes to complications from small bowel metastases by two mechanisms. First, rapid tumor growth may replace the full-thickness of the bowel wall so that subsequent tumor necrosis will result in perforation. Second, a large tumor mass may obstruct the lumen or cause an intussusception.

Segmental resection of the obstructed, intussuscepted, or perforated portion of small bowel is usually possible. Long term prognosis, however, is poor, with death occuring within four months after presentation of the small bowel symptoms. Although rare, small bowel metastasis should be considered whenever a patient with a previous malignancy presents with signs of gastrointestinal perforation or small bowel obstruction. Surgical intervention should be undertaken for palliation. ◀

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	Melvin Freedman	Rosalyn Lepley
	Robert F. Hamilton	Edward Ragsdale
MORGAN-SCOTT	Frank Norbury	Joseph Winterhalter
PIKE	Carlos B. Lara	Ronald L. Johnson
District #7		
BOND	Boyd McCracken, Sr.	M. K. Kaufmann
CHRISTIAN	M. T. Salaymeh	Edward D. Slifer
CLAY		
CLINTON	Wilson L. DuComb	Michael Bateman
EFFINGHAM		
FAYETTE	Joshua Weiner	Hans Rollinger
MACON (2)	J. Stroyls	C. G. Glenn
	H. Gale Zacheis	C. O. Stanley
MARION	Richard Rudman	E. F. Stephens, III
MOULTRIE	Eugene J. Boros	Phillip Best
PIATT	George G. Green	William E. Mundt
SHELBY	Edwin J. Siroy	Urbano Dauz
District #8		
CHAMPAIGN (3)	Harlan Failor	Victor Feldman
	Jack Hull	Harold Kolb
	Arthur R. Traugott	Ray Tirona
CLARK	Dorothy Hubler	Steven Macke
COLES-CUMBERLAND	Mack W. Hollowell	Joseph Mallory
CRAWFORD	Charles Salesman	Dean J. Pelley
DOUGLAS	Robert N. Arrol	Grant Jones
EDGAR	J. M. Ingalls	Duane Haskell
JASPER		
LAWRENCE	Larry Herron	R. J. Nichols
RICHLAND	Charles A. DeKovessey	
VERMILION	Grover W. Seitzinger	W. F. Hensold
District #9		
ALEXANDER	Gemo Y. Wong	Charles L. Yarbrough
EDWARDS		
FRANKLIN	James Durham	

County	*Delegates*	*Alternate Delegates*
Gallatin	John E. Doyle	
Jackson	Paul P. Lorenz	Eli L. Borkon
Jefferson-Hamilton	Charles K. Wells	H. Goff Thompson
Johnson		
Massac	Enrique Y. Yap	Benito Bajuyo
Pulaski	A. L. Robinson	
Saline-Pope-Hardin	A. Z. Goldstein	Larry Jones
Union	Thomas Davis	William Whiting
Wabash	E. Lowenstein	Roger Fuller
Wayne	C. J. Jannings, III	E. B. Loftin
White	Phillip Boren	
Williamson	Herbert V. Fine	Robert Kane

District #10

Monroe	Russell W. Jost	E. F. Maglasang
Perry	C. E. Cawvey	B. A. Kinsman
Randolph	O. W. Pflasterer	Allan Liefer
St. Clair (3)	Loyd Thompson	Wallace Berkowitz
	Robert Wanless	Charles Frazer, Jr.
	Ronald Welch	Donald I. Serot
Washington	Thomas J. Coy	

District #11

Dupage (9)	James P. Campbell	Orren D. Baab
	William B. Frymark	Anita Balodis
	Joseph P. McKay	Peter Brusca
	Morgan M. Meyer	Raymond A. Dieter, Jr.
	Joseph R. O'Donnell	Robert D. Dooley
	William C. Perkins	Robert Fitzgerald
	Ronald M. Severino	Sharon Pelton
	Thomas W. Stach	Leo Roberts
	Harold Walgren	Garth Smith
Ford	Ross Hutchison	Somchai Supawanich
Iroquois	R. K. Swedlund	J. E. Dailey
Kankakee	Donald Parkhurst	Richard Stoval
Kendall	Walter H. Brill	Michael R. Saxon
Will-Grundy (4)	Robert J. Becker	Van L. Hicks
	Albert W. Ray, Jr.	Kenneth P. Jesunas
	Stanley Rousonelos	Theodore Kanellakes
	Kenneth M. Uznanski	John D. Walter

District #12

Boone	Earl Davis	Kent Hess
Carroll	Ronald Miller	C. G. Piper
DeKalb	John W. Ovitz, Jr.	Dean Miller
Jo Daviess	Francis Waites	Delbert Williams
Lee	Donald Edwards	Osama A. Almasri
Ogle	Don E. Hinderliter	Vincenzo Traina
Stephenson	William H. Isham	F. H. DesCourouez
Whiteside	John Hubbard	
Winnebago (5)	Robert Behmer	Gareth Eberle
	Raymond Hoffmann	William Kobler
	F. H. Riordan, III	Warren Lowry
	Richard S. Webb	Burton Moore
	Jerome Weiskopfe	Fred Nathan
Medical Student Section	Ronald Davis	Malcolm Major
Resident Physicians Section	William E. Golden	John Hall

Officers of County Medical Societies 1981

County	President	Secretary
Adams Members: 105-Dist 6 Maxine Boyer, Ex. Sec. 1118 Broadway Quincy 62301	Peter L. Leffman 1416 Main, Quincy 62301	Richard L. Newman 1124 Broadway, Quincy 62301
Alexander Members: 10-Dist. 9	Gemo Wong 529 Cross, Cairo 62914	Charles L. Yarbrough 800 Commercial, Cairo 62914
Bond Members: 9-Dist. 7	John K. Dawdy 100 N. Locust, Greenville 62246	Thomas D. Dawdy 100 N. Locust, Greenville 62246
Boone Members: 22-Dist. 12	Maurice J. Carlisle 115 W. Lincoln, Belvidere 61008	John Steinkamp 824 S. Van Buren, Belvidere 61008
Bureau Members: 40-Dist. 2	Ruben Santos 600 E. 1st St., Spring Valley 61362	Swasdi Pothikamjorn 4040 Progress Blvd., Peru 61354
Carroll Members: 8-Dist. 12	Benjamin Sy Savanna Medical Center, Savanna 61074	Basilios Lambos 101 Broad St., Lanark 61046
Cass-Brown Members: 1-Dist. 6		
Champaign Members: 230-Dist. 8 Larry Booth, Ex. Sec. 1408 W. University Urbana 61801	Robert E. Welke 602 W. University, Urbana 61801	Paul W. Yardy 602 W. University, Urbana 61801
Christian Members: 26-Dist. 7	Deogracias F. Quizon 217 S. Locust, Pana 62557	I. Del Valle 311 S. Main, Taylorville 62568
Clark Members: 6-Dist. 8	George T. Mitchell Cork Medical Center, Marshall 62441	Eugene P. Johnson P. O. Box 68, Casey 62420
Clay Members: 7-Dist. 7	Donald L. Bunnell Flora Clinic, Flora 62839	Eugene Foss P.O. Box 250, Flora 62839
Clinton Members: 12-Dist. 7	Michael A. Bateman 541 Ninth St., Carlyle 62231	James A. Kirby 401 N. Main, Breese 62230
Coles-Cumberland Members: 55-Dist. 8	Frank L. Miller 1700 Wabash, Mattoon 61938	Ronald D. Miller 1700 Wabash, Mattoon 61938
Cook Members: 8498-Dist. 3 Fred Schwartz, Exec. Dir. 515 N. Dearborn St. Chicago, IL 60610	Robert C. Hamilton 25 E. Washington, Chicago 60602	Richard H. Blankshain 715 Lake St., Oak Park 60301
Crawford Members: 11-Dist. 8	Frank Gross 1002 Allen, Robinson 62454	W. B. Schmidt Schmidt Clinic, Robinson 62454
DeKalb Members: 63-Dist. 12	Ivan H. Shils 232 S. Second, DeKalb 60115	William F. Stach 407 W. State St., Sycamore 60178
DeWitt Members: 10-Dist. 5	John W. Veirs 219 E. Main, Clinton 61727	C. N. Radhakrishna 210 E. Main, Clinton 61727
Douglas Members: 7-Dist. 8	Robert N. Arrol 126 S. Locust, Arcola 61910	Grant A. Jones 318 S. Ash, Arthur 61911
DuPage Members: 707-Dist. 11 Lillian Widmer, Ex. Sec. 26 W. St. Charles Rd. Lombard, IL 60148	Harold N. Walgren 4333 Main St., Downers Grove 60515	James P. Campbell 322 N. Blanchard St., Wheaton 60187

County	President	Secretary
Edgar Members: 15-Dist. 8	Duane Haskell 502 Shaw, Paris 61944	J. M. Ingalls Medical Center Clinic, Paris 61944
Effingham Members: 16-Dist. 7	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401	P. D. L. Nayak 401 N. Mulberry St. Effingham 62401
Fayette Members: 7-Dist. 7	Joshua Weiner 1007 N. Eighth St., Vandalia 62471	Vasudev Kachgal 802 N. Eighth St., Vandalia 62471
Ford Members: 11-Dist. 11	George Elfers Bellflower 61724	Paul W. Sunderland 214 N. Sangamon, Gibson City 60936
Franklin Members: 30-Dist. 9	Talivaldis Kisle 502 W. Franklin, Sesser 62884	R. G. Thompson 309 W. St. Louis St., W. Frankfort 62896
Fulton Members: 40-Dist. 4	Jai Chul Cha 210 W. Walnut, Canton 61520	John H. Day 175 S. Main, Canton 61520
Gallatin Members: 2-Dist. 9		John E. Doyle Ridgway 62979
Greene Members: 6-Dist. 6	Jose P. Parcon 11 Edgewood Drive, Carrollton 62016	James C. Reid 712 S. College, Greenfield 62044
Hancock Members: 12-Dist. 4	Vasant Pawar Memorial Hospital, Carthage 62321	James E. Coeur 630 Locust, Carthage 62321
Henderson Members: 2-Dist. 4	Farouk El Khatib Stronghurst Med. Cntr., Stronghurst 61480	Silvino Lindo, Jr. Biggsville 61418
Henry-Stark Members: 36-Dist. 4	Renato Judalena 513 Elliott St., Kewanee 61443	Hipolito C. Lopez, Jr. 716 Elliott, Kewanee 61443
Iroquois Members: 20-Dist. 11	C. P. DeVas Gunawardhane PO Box 638, Clifton 60972	Jeffery Swider 106 Prof. Arts Bldg., Rts 1 & 24E Watseka 60970
Jackson Members: 113-Dist. 9	Antoinette G. Thomas 404 W. Main, Carbondale 62901	Adiraju Palagiri 2601 W. Main, Carbondale 62901
Jasper Members: 2-Dist. 8	Monico Low 609 S. Van Buren, Newton 62448	Juan J. Serra 507 W. Washington, Newton 62448
Jefferson-Hamilton Members: 37-Dist. 9	H. Goff Thompson 1708 Jefferson, Mt. Vernon 62864	Kenneth Peart #1 Doctors Park, Mt. Vernon 62864
Jersey-Calhoun Members: 10-Dist. 6	Robert G. Mindrup 300 S. Washington, Jerseyville 62052	Bernard Baalman Medical Center, Hardin 62047
Jo Daviess Members: 9-Dist. 12	David Hockman 300 Summit St., Galena 61036	Wilbur Johnson 300 Summit St., Galena 61036
Kane Members: 320-Dist. 1 H. Michael Wild, Ex. Dir. 355 First St. Batavia 60510	William T. Sheehy 1187 Dundee Ave., Elgin 60120	John A. O'Dwyer 34 N. Water, Batavia 60510
Kankakee Members: 111-Dist. 11	Donald G. Parkhurst 401 N. Wall, Kankakee 60901	Charles F. Lind 500 W. Court St., Kankakee 60901
Kendall Members: 8-Dist. 11	Walter Brill Main St., Oswego 60543	John P. Cullinan Oswego 60543
Knox Members: 82-Dist. 4 Mrs. Jane Gau, Exec. Sec. Galesburg Cottage Hospital 695 N. Kellogg Galesburg, IL 61401	Gene E. Johnson 3315 N. Seminary, Galesburg 61401	Martin D. McDermott 555 N. Kellogg, Galesburg 61401

County	President	Secretary
Lake Members: 415-Dist. 1 Julia Schultz, Ex. Sec. P.O. Box 148 Gurnee, Ill. 60031	James R. Creath 1345 Wilson Dr., Lake Forest 60045	Ronald B. Klimaitis 890 Garfield, #210, Libertyville 60048
LaSalle Members: 102-Dist 2	Eleanor E. Howell 811 N. Bloomington, Streator 61364	Allan L. Goslin 712 N. Bloomington, Streator 61364
Lawrence Members: 13-Dist. 8 Ruth E. Gariepy, Ex. Sec. Lawrence City. Mem. Hosp. Lawrenceville 62439	Robert J. Nichols P.O. Box 907, Vincennes, Ind. 47591	Francisco E. Martin 542 N. Main, Bridgeport 62417
Lee Members: 24-Dist. 12	Jeffery Wexler Rural Route 3 Dixon 61021	Joseph Elie McNichols Clinic, 120 S. Hennepin Ave. Dixon 61021
Livingston Members: 27-Dist. 2	Rajendra Shrivastav 612 E. Water, #107, Pontiac 61764	Karl T. Deterding 612 E. Water, #109, Pontiac 61764
Logan Members: 25-Dist. 5	Edward Ulrich 311 8th St., Lincoln 62656	Wayne J. Schall 311 8th St., Lincoln 62656
Macon Members: 163-Dist. 7 Mary J. Bretz, Ex. Sec. 1800 E. Lake Shore Dr. Decatur 62521	Giles Richard Locke 2300 N. Edward, Decatur 62521	H. Gale Zacheis 2220 N. Monroe, Decatur 62526
Macoupin Members: 19-Dist. 6	Robert H. Rutherford 224 E. Main, Carlinville 62626	Robert England 935 Morgan, Carlinville 62626
Madison Members: 208-Dist. 6	Laurence A. Heineman 1100 Broadway Ave., Highland 62249	Norman E. Taylor 95 S. 9th St., E. Alton 62024
Marion Members: 44-Dist. 7	Louis E. Jorel Rt. 37 North, Salem 62881	W. P. Plassman Box 552, Centralia 62801
Marshall-Putnam Members: 3-Dist. 2	Joe W. Cannon 202 S. Main, Lacon 61540	Donald M. Gallagher Box 538, Granville 61326
Mason Members: 5-Dist. 5	Henry W. Maxfield 315 E. Chestnut, Mason City 62664	Henry W. Maxfield 315 E. Chestnut, Mason City 62664
Massac Members: 3-Dist. 9	Enrique T. Yap 510 W. 10th St., Metropolis 62960	Benito Bajuyo P.O. Box 187, Metropolis 62960
McDonough Members: 30-Dist. 4	Budris Andernovics Industry 61440	David Reem 505 E. Grant, Macomb 61455
McHenry Members: 78-Dist. 1 Evelyn Rosulek, Ex. Sec. 308 E. Kimball Woodstock 60098	Ted L. Rolander 1110 N. Green, McHenry 60050	Robert E. Stanell 3516 W. Waukegan Rd., McHenry 60050
McLean Members: 128-Dist. 5 Carol Toperzer, Exec. Sec. 1236 E. Empire Bloomington 61701	David L. Doud 900 Franklin, Normal 61761	John R. Krueger #1 Medical Hills Dr., Bloomington 61701
Mercer Members: 5-Dist. 4	Monty P. McClellan 309 NW 2nd St., Aledo 61231	Dennis D. Palmer 409 NW Fourth, Aledo 61231
Monroe Members: 10-Dist. 10	Ingeborg M. Kremer 854 Bottom, Columbia 62236	Chong K. Park 405 W. South 4th, Red Bud 62278
Montgomery Members: 20-Dist. 5	Roger Wujek 1215 E. Union, Litchfield 62056	James T. Foster 8 Arrowhead Rd., Litchfield 62056

County	President	Secretary
Morgan-Scott Members: 50-Dist. 6	Robert M. Roy 1515 W. Walnut, Jacksonville 62650	Jeffery L. Belden 200 W. State, Jacksonville 62650
Moultrie Members: 4-Dist. 7	Phillip Best 14 N. Washington, Sullivan 61951	Dean McLaughlin 112 E. Harrison, Sullivan 61951
Ogle Members: 16-Dist. 12	L. T. Koritz 324 Lincoln, Rochelle 61068	Russell Zack 915 Caron, Rochelle 61068
Peoria Members: 419-Dist. 4 M. John Hanni, Jr., Ex. V.P. 427 1st National Bank Bldg. Peoria 61602	Stuart S. Roberts 427 1st Nat'l. Bank Bldg., Peoria 61602	Frederick Heinzen 427 1st Nat'l. Bank Bldg., Peoria 61602
Perry Members: 15-Dist. 10	Gene Stotlar i3 N. Walnut St., Pinckneyville 62274	Bill R. Fulk 207 E. Main, DuQuoin 62832
Piatt Members: 4-Dist. 7	George Green 1111 N. State, Monticello 61856	Joseph Allman 121 N. State, Monticello 61856
Pike Members: 11-Dist. 6	Warren C. Barrow 321 W. Washington, Pittsfield 62363	T. C. Bunting 321 W. Washington, Pittsfield 62363
Pulaski Members: 1-Dist. 9	A. L. Robinson Box 277, Mounds 62964	
Randolph Members: 20-Dist. 10	Allan L. Liefer 415 W. S. Fourth, Red Bud 62278	J. M. Whittenberg 1650 State St., Chester 62233
Richland Members: 24-Dist. 8	Don F. Hatten 408 N. Mill St., Olney 62450	Chandra Varadachari Richland Memorial Hosp., Olney 62450
Rock Island Members: 197-Dist. 4 James A. Koch, Ex. Sec. 612 Kahl Bldg. Davenport, Iowa 52801	Robert M. Wells 2508-25th, #F, Rock Island 61201	Miguel Flores 532 19th, Moline 61265
St. Clair Members: 272-Dist. 10 Ed Belz, Ex. Sec. 6400 W. Main Belleville 62223	Thomas P. Meirink 8601 W. Main, Belleville 62223	Casimiro C. Garcia, Jr. 6400 W. Main, #1F, Belleville 62223
Saline-Pope-Hardin Members: 32-Dist. 9	Elliott O. Partridge 1201 Pine, Eldorado 62930	Warren R. Dammers P.O. Box 281, Harrisburg 62946
Sangamon Members: 402-Dist. 5 L. R. Brosi, Ex. Dir. 1 N. Old State Capitol Plaza Springfield 62701	P. F. Mahon 1 N. Old State Capitol Plaza Springfield 62701	Michael C. Snyder 800 E. Carpenter, Springfield 62702
Schuyler Members: 4-Dist. 4	R. R. Dohner 103 W. Washington, Rushville 62681	Henry C. Zingher West Side Square, Rushville 62681
Shelby Members: 9-Dist. 7	P. D. Gurujal Shelby City. Med. Cntr., Shelbyville 62565	Otto G. Kauder P.O. Box 225, Shelbyville 62565
Stephenson Members: 57-Dist. 12	Frederick M. Mosher 1036 W. Stephenson, Freeport 61032	George Lagen 1045 W. Stephenson, Freeport 61032
Tazewell Members: 75-Dist. 4 Colleen Ingersoll, Exec. Sec. P.O. Box 778 Pekin 61554	Mahboob A. Sheikh P.O. Box 778, Pekin 61554	Robert F. Gregorski P.O. Box 778, Pekin 61554

County	President	Secretary
Union Members: 12-Dist. 9	Thomas W. Davis 319 S. Main St., Anna 62906	Carroll O. Loomis Union County Hosp., Main St., Anna 62906
Vermilion Members: 113-Dist. 8	Edward N. Hetherington 715 W. Fairchild, Danville 61832	Michael Lomax 723 N. Logan, Danville 61832
Wabash Members: 5-Dist. 9	Ernest Lowenstein 1123 Chestnut, Mt. Carmel 62863	C. L. Johns 114 W. 5th St., Mt. Carmel 62863
Warren Members: 14-Dist. 4	Kenneth E. Ambrose 219 E. Euclid, Monmouth 61462	Glenn W. Chamberlin 219 E. Euclid, Monmouth 61462
Washington Members: 6-Dist. 10	Ralph Kelley 113 W. St. Louis, Nashville 62263	Charles Longwell 111 S. Washington, Nashville 62263
Wayne Members: 9-Dist. 9	Eugene B. Loftin 301 NW 11th, Fairfield 62837	David A. Gershenson 308 E. Main St., Fairfield 62837
White Members: 8-Dist. 9	Phillip D. Boren Doctors Clinic, Carmi 62821	Morris A. McCall Doctors Clinic, Carmi 62821
Whiteside Members: 53-Dist. 12	Reda M. Salama 1601 First Ave., Sterling 61081	Girish Bhatt 101 E. Miller Rd., Sterling 61081
Will-Grundy Members: 254-Dist. 11 Ronald W. Batozech, Ex. Sec. 3033 W. Jefferson Suite 220 Joliet 60435	Daniel Gutierrez 1255 Eagle St., Joliet 60432	Amin M. Khater 1106 N. Larkin, Joliet 60435
Williamson Members: 38-Dist. 9	M. T. Joseph 106 S. Vicksburg, Marion 62959	Herbert V. Fine 110 N. Division, Carterville 62918
Winnebago Members: 399-Dist. 12 Robert Carlson Exec. Adm. 310 N. Wyman St. Rockford 61101	Robert H. Lund 2300 N. Rockton, Rockford 61101	William E. Kobler 5670 E. State St., Rockford 61108
Woodford Members: 7-Dist. 2	Hans W. Riggert 101 S. Davenport, Metamora 61548	James W. Riley 109 S. Major, Eureka 61530

No Organized County Society

Edwards
Johnson
Menard

Joint County Societies

Cass-Brown
Coles-Cumberland
Henry-Stark
Jefferson-Hamilton
Jersey-Calhoun
Marshall-Putnam
Morgan-Scott
Saline-Pope-Hardin
Will-Grundy

The Illinois State Medical Society has developed the council and committee structure to facilitate the activities and responses of its members. Council and committee members are selected annually, based on suggestions and nominations of trustees, delegates, and county medical societies. Appointments are made by the Chairman of the Board of Trustees, with approval of the Board.

Please notify your trustee if you wish to be considered for appointment. The various activities are as listed in the Reference Issue (November). Members who wish to notify the Chairman of the Board of their availability can clip and submit the coupon below.

NAME: _____ CITY: _____ ZIP: _____

ADDRESS: _____

TELEPHONE: () _____

COUNTY MEDICAL SOCIETY: _____

MEDICAL SPECIALTY AND TYPE OF PRACTICE: _____

COMMITTEE IN WHICH INTERESTED: _____

EXPERTISE FOR THIS COMMITTEE: _____

SEND TO: Chairman, Board of Trustees, Illinois State Medical Society
55 E. Monroe, Suite 3510, Chicago, IL 60603

Resolutions for 1981 Interim Session ISMS House of Delegates

The following resolutions were received at ISMS headquarters by September 5 and, according to provisions of the bylaws, are printed in *IMJ* by title and subject. As a result of recent action by the House of Delegates, the Committee on Rules and Order of Business is responsible for recommending whether or not resolutions submitted by individual delegates will be considered by the House at an interim session or held over for the next annual meeting.

Final deadline for resolutions was October 8. At this writing, it is anticipated that other resolutions will have been submitted and accepted for consideration before that deadline. These will be included in the Delegates' Packet of materials.

Number:	*Introduced by:*	*Subject*
1 (I-81)	Alfred J. Kiessel, M.D., for the Board of Trustees	Revision in Policy on Legislation
2 (I-81)	Alfred J. Kiessel, M.D., for the Board of Trustees	Deletion of Policy on Reference Committee Appointments
3 (I-81)	Morris T. Friedell, M.D., for the Board of Trustees	Amendment of Policy Manual Statement on "Physicians"

Committees of the House of Delegates 1981 Interim Meeting

The purpose of the Reference Committee is to consider and report to the House of Delegates its recommendations upon resolutions being considered. Reference Committees of the House of Delegates shall be appointed by the Speaker of the House as necessary. For the 1981 interim session, there will be three Reference Committees—A, B and C. They will consider such resolutions as referred by the Speaker.

COMMITTEE ON RULES & ORDER OF BUSINESS

This committee shall consider all matters regarding rules governing actions, methods and procedures, and the order of business (agenda) for the session of the House of Delegates. It shall work in close cooperation with the Speaker and Vice Speaker.

Resolutions submitted after the deadline for receiving resolutions (four weeks prior to the annual or interim meeting) must be approved by the Committee on Rules and Order of Business, or by a two-thirds vote of the House, before they will be considered as business of the House of Delegates.

The committee shall contact the Speaker just prior to each session of the House to make sure that all recommendations for House action are included in its report.

In addition, the Committee on Rules and Order of Business must approve all resolutions submitted by individual delegates, the Resident Physician Section and the Medical Student Section in order to be considered at any interim session of the House of Delegates. Resolutions not approved by this committee will be held over for the next annual meeting.

COMMITTEE ON CREDENTIALS

This committee shall consider all questions regarding the registration and certification of delegates. The chairman shall keep the Speaker of the House informed of the voting power thereof

The committee shall distribute and receive the attendance slips and perform such other duties as may be assigned by the Speaker.

This committee shall meet at least one hour prior to the opening session of the House and one-half hour prior to the opening of the other sessions.

TELLERS AND SERGEANTS AT ARMS

This committee shall serve the Speaker of the House of Delegates whenever a vote count is called for, whenever a ballot is scheduled, or the House goes into executive session.

REFERENCE COMMITTEE ON AMENDMENTS TO CONSTITUTION & BYLAWS

This committee shall consider and report to the House of Delegates its recommendations on all proposed amendments to the Constitution and Bylaws.

ILLINOIS DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

Report to the House of Delegates

The Illinois Delegation to the AMA introduced six resolutions for consideration by the House of Delegates at the 1981 annual AMA meeting in Chicago. Following is the action taken on each:

Resolution 58: Abolishing Health Systems Agencies. Adopted on recommendation of the reference committee, which stated: "Resolution 58 asks that, until HSAs are abolished, penalties on states out of compliance with federal SHPDA criteria be eliminated. The committee is aware that legislative action is already underway to abolish the National Health Planning Act, but notes that Resolution 58 defines a problem which should be addressed in the interim."

Resolution 59: Manipulative Casting of Congenital Deformities of the Extremities. Referred to the Board of Trustees on recommendation of the reference committee, which stated: Resolution 59 urges that all third party payors should consider manipulative casting of congenital deformities of the extremities a surgical procedure, wherever performed. Testimony heard during the reference committee indicated that Resolution 59 in its current construction does not appear to remedy the presumably addressed problem. The issue on its own merits is, however, significant and deserves a thorough review of the Board of Trustees.

Resolution 60: Commercial Review of Hospital Utilization. The following substitute (introduced by the Illinois Delegation) was adopted in lieu of a substitute recommended by the reference committee:

> "RESOLVED, That the American Medical Association notify all agencies involved in medical peer review that the medical peer review be done only by physician sponsored organizations."

The original Resolution 60 would have the AMA express to the American Hospital Association its opposition to any attempts by hospitals to bypass physician review organizations by providing commercial review of hospital utilization directly to interested businesses. The reference committee's substitute would have allowed such review under the guidance or direction of the medical profession.

Resolution 61: Statellite Emergency Clinics. Referred to the Board of Trustees for report back to the House of Delegates at the 1981 interim meeting. Resolution 61 asks that the AMA study and report on the operation of satellite emergency clinics subsidized by hospitals. Testimony presented before the reference committee expressed concern over apparent growth in hospital satellite services. One witness testified that an ad hoc committee already is exploring this problem area. In light of this testimony, most of the witnesses supported referring this resolution to the Board of Trustees.

Resolution 62: Multiple Coverage Options. Adopted as an item in Consent Calendar. The resolution asks that AMA endorse the principle that, under federal rules and regulations, the costs and premiums for health care—whether incurred directly by an individual or conferred as an employee benefit—should be equally deductible.

Resolution 63: Tax Credits or Deductions in Lieu of Direct Reimbursement for Treatment of Medicaid Patients. This resolution—along with a similar Pennsylvania resolution—was referred to the Board of Trustees for "prompt action and disposition." The reference committee stated that: "These resolutions present an approach intended to increase physician acceptance of Medicaid patients by supplementing or replacing Medicaid payment with federal income tax credits or deductions. While the Committee is aware of the attractions of this concept, and the increasing problems with Medicaid, it feels that the complexities inherent in the implementation of this approach and both its potential for advantage and disadvantage require deeper exploration than is possible at this time.

Highlights of the Meeting

The delegation met every day during the session, with all members present, except Dr. Maynard Shapiro, who was hospitalized. Dr. Cyril Wiggishoff was seated for Dr. Shapiro, with Michael Nieder, student representative, credentialed as an alternate for Dr. Wiggishoff. Dr. George Wilkins served as a member of the Reference Committee on Amendments to Constitution and Bylaws and Dr. Joseph O'Donnell was

a member of the Committee on Rules and Order of Business. Dr. Harold Lasky acted as a teller.

Dr. Joseph Skom was elected a member of the Council on Scientific Affairs. Dr. Ira Friedlander was elected resident member of this council. Dr. Ann Nunnally was re-elected to the Council on Medical Education. For the first time, the delegation participated in group interviewing of candidates. Others involved were representatives of Indiana, Michigan, Ohio and New York.

By official action, the Delegation voted to support the candidacy of Dr. Frank J. Jirka, Jr., for President-Elect of the AMA in 1982. He was so notified by the Chairman of the ISMS Board of Trustees, Dr. Friedell, and the Chairman of the AMA Delegation, Dr. Grevas.

The Delegation endorsed several suggestions for increasing its effectiveness and requested staff to develop further recommendations.

Theodore Grevas, M.D.
Chairman
Howard C. Burkhead, M.D.
Secretary

ISMS DELEGATION TO THE AMA

Delegation Chairman: Theodore Grevas; Secretary: Howard C. Burkhead

Delegates

To serve from Jan. 1, 1980 to December 31, 1981
(Elected May 9, 1979)

Herschel Browns, Chicago
Howard C. Burkhead, Evanston
Jack L. Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Maynard I. Shapiro, Chicago
Joseph Skom, Chicago

To serve from Jan. 1, 1981 to Dec. 31, 1982
(Elected April 15, 1980)

David S. Fox, Chicago
Morris T. Friedell, Chicago
Henrietta Herbolsheimer, Chicago
Lawrence L. Hirsch, Chicago
Joseph R. O,Donnell, Glen Ellyn
John J. Ring, Mundelein
Glen E. Tomlinson, Lincoln
George T. Wilkins, Jr., Granite City

To serve from January 1, 1982 to December 31, 1983
(Elected April 7, 1981)

Herschel Browns, Chicago
Howard Burkhead, Evanston
Jack Gibbs, Canton
Theodore Grevas, Rock Island
Morgan M. Meyer, Lombard
Maynard I. Shapiro, Chicago
Joseph Skom, Chicago

Alternate Delegates

To serve from Jan. 1, 1980 to Dec. 31, 1981
(Elected May 9, 1979)

Alfred Clementi, Arlington Heights
Allan L. Goslin, Streator
Robert Hamilton, Chicago
Robert R. Hartman, Jacksonville
Eugene P. Johnson, Casey
Harold Lasky, Chicago
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago

To serve from Jan. 1, 1981 to Dec. 31, 1982
(Elected April 15, 1980)

Andrew J. Brislen, Chicago
Audley F. Connor, Jr., Chicago
Robert P. Johnson, Springfield
Boyd McCracken, Sr., Greenville
Clifton L. Reeder, Wilmette
Richard Rovner, Chicago
P. John Seward, Rockford

To serve from January 1, 1982 to December 31, 1983
(Elected April 7, 1981)

Alfred Clementi, Arlington Heights
Allan Goslin, Streator
Robert C. Hamilton, Chicago
Harold Lasky, Chicago
Arthur Traugott, Urbana
Ronald Welch, Belleville
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago

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ILLINOIS STATE MEDICAL SOCIETY

SCHEDULE OF MEETINGS

Springfield Hilton

Leadership Conference

November 5-8

Thursday and Friday, November 5-6

A one and one-half day workshop on negotiating skills will be held prior to the ISMS House of Delegates Interim Session. **Negotiation: A Leadership Skill** is co-sponsored by ISMS and the AMA Department of Negotiations. Participation will be limited to permit small group discussions, so advance registration will be required. Registration fee is $125. Further information will be available in the Delegates' Packet or by calling the Division of Medical Services, (312) 782-1654. The program has been accredited for 13 hours of Category 1 CME credit toward the AMA Physician Recognition Award.

Saturday, November 7

8:30 a.m. — **HMO-IPA Slide Presentation**
An educational slide presentation describing basic components of Health Maintenance Organizations and Individual Practice Associations has been developed by the ISMS Council on Economics. The 20 minute program reviews the beginnings of prepaid medical care, the different models of HMOs and the advantages and disadvantages of participation in this form of health care delivery system.

9:00 a.m. — State Department Directors Address Conference

3:30 p.m. — Key Legislators Address Conference

4:30 p.m. — HMO-IPA Slide Presentation (repeat)

6:00 p.m. — Reception, Old State Capitol Building

Interim Session, House of Delegates

November 7-8

Saturday, November 7

8:00 a.m. Delegate registration opens

8:00 a.m. Delegates check in with Credentials Committee

9:30 a.m. Meeting of reference committee personnel

10:00 a.m. House of Delegates meeting

11:30 a.m. District caucuses and delegates buffet

2:00 p.m. Reference committee meetings

Sunday, November 8

9:00 a.m. Delegates check-in with Credentials Committee

9:30 a.m. House of Delegates meeting

Case Reports

Middle-Aged Patient with Multiple Pulmonary Nodules

By William J. Marx, M.D./Rockford

Chronic, severe, iron-deficiency anemia was seen in a 57-year-old patient presenting with epistaxis. Her medical history was punctuated with numerous episodes of epistaxis, hematemesis, and hemoptysis occurring over the span of many years. She exhibited clubbing of the fingers and telangiectasia on her lips and in her mouth. Other family members had similar clinical findings. Posterior-anterior and lateral chest roentgenograms of this patient showed multiple pulmonary nodules. (Figures 1 and 2)

The diagnosis was hereditary hemorrhagic telangiectasia (Osler-Weber-Rendu disease) with pulmonary arteriovenous fistulas (AVF).

Comment

The posterior-anterior (Figure 1) and lateral (Figure 2) chest roentgenograms show: a solitary, umbilicated nodule in the anterior segment of the right upper lobe with apparent connection to a segmental pulmonary vessel and a small cluster of lobulated masses in the superior segment of the left lower lobe. Tomography of these lesions demonstrated direct connections between these nodules and the pulmonary vascular tree, confirming the diagnosis of arteriovenous fistulas.

Although not included in the original descriptions of hereditary hemorrhagic telangiectasia, pulmonary AVF are a common manifestation. Forty to sixty-five percent of these patients have similar lesions elsewhere, including the skin, mucous membranes, and visceral organs.[1-3] Although the congenital vascular defect is present at birth, clinical symptoms generally manifest in the third decade of life, though they may occur earlier.[4,5]

Although these patients may be clinically asymptomatic, Moyer *et. al.*, found most to have symptoms of multiple telangiectasia, including epistaxis, hematemesis, cerebral vascular hemorrhage, or hemoptysis.[1] In classic cases such patients have cyanosis, finger clubbing, and exertional dyspnea. Most patients have polycythemia, but repeated hemorrhages may lead to anemia.[2,6] Frequently, bruit can be heard over the pulmonary lesions; this is usually continuous and heard loudest in deep inspiration.[1,7] The symptoms of pulmonary AVF are related to pathophysiologic interference with gaseous exchange or to chronic bleeding.[1,8]

Pulmonary AVF may be either acquired or congenital. Acquired fistulas may be seen following trauma; they have also been reported in association with pulmonary schistosomiasis,[9] long-standing cirrhosis,[10] and metastatic thyroid carcinoma.[11] Congenital lesions are due to a defect in the terminal capillary loops. Histological examination of these lesions shows dilated vessels composed of a single layer of endothelium. These fragile, thin-walled vascular sacs, which rupture easily, are fed by a single artery and drained by a single, distended vein.[4,12]

Most pulmonary AVF are found in the lower lung zones, more commonly of the right.[1,12-14] Many are situated just beneath the pleura, between lobules, along bronchovascular bundles, and in the mediastinal pleura.[12] Most often the lesions are single, but multiple lesions are also common.

Pathophysiologic changes include shunting of blood from the pulmonary artery to the pulmonary vein without gaseous exchange.[1,8] Arterial unsaturation occurs and cyanosis ensues. The hypoxemia stimulates erythropoiesis and compensatory polycythemia develops. The increase in blood volume is mainly cellular. Hematocrits up to 90% and red cell counts between 7-10 million per cubic millimeter are sometimes seen.[1] The WBC is usually normal.

On roentgenograms, pulmonary AVF are seen most commonly in the lower lobes and in two thirds of the cases are single lesions.[1,12] They usually present as rounded or smoothly lobulated, homogeneous, sharply defined soft tissue masses. Visualization of the feeding artery and the draining vein, which is essential to the diagnosis, is often ac-

WILLIAM JAMES MARX, M.D., is a board certified diagnostic radiologist affiliated with Swedish American Hospital in Rockford. A clinical professor of radiology at the UI Rockford School of Medicine, Dr. Marx is a member of numerous professional associations.



Figure 1a (left) and Figure 1b

PA and Lateral Chest with open arrow and black arrows identifying pulmonary nodules.

complished by routine radiography, although sometimes tomography is needed to demonstrate these vessels. In rare instances, arteriography is needed to establish a diagnosis. If surgery is to be performed, however, arteriography is necessary to accurately define the exact number and extent of the lesions present. The lesions rarely calcify. During fluoroscopic examination the lesions may be seen to change size with respiration. Valsalva and Mueller maneuvers may accentuate this dynamic presentation.[12]

Summary

Pulmonary arteriovenous fistula are a common manifestation of hereditary hemorrhagic telangiectasia (Osler-Weber-Rendu disease). The presence of skin or mucous membrane telangiectasia or a history of the classical triad of cyanosis, finger clubbing, and exertional dyspnea in a patient with a pulmonary coin lesion should suggest the diagnosis. ◀

References

A complete set of references for "Middle-Aged Patient with Multiple Pulmonary Nodules," may be obtained by writing the *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago 60603.

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Anonymous

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Abstracts of Board Actions

(Continued from page 213)

PROGRAMS/CONFERENCES

The Board took the following actions with regard to sponsorship of educational seminars and other programs:

- Endorsed development of a full-day format for loss prevention education programs to be presented up to three times at regional locations, with a registration fee of $50 for members and $200 for non-members. The Board also approved continuation of current loss prevention education committee and program activity for another year.
- Agreed to co-sponsor the SIU School of Medicine's annual Doctor's Job Fair to be held in Springfield September 9, provided it meets the Society's guidelines for co-sponsorship.
- Approved sponsorship of six travel programs offered by INTRAV, including: (1) Western Mediterranean Air/Sea Cruise, 12 days, Oct. 16; (2) Mexican Riviera Air/Sea Cruise, 7 days, January, February, March or April, 1982; (3) Nile River Adventure, 14 days, April or May, 1982; (4) Scandinavian Adventure, 14 days, June or July, 1982; (5) Canadian Rockies Adventure, 10 days, September or October, 1982; and (6) Adriatic/Greek Isles Adventure, 14 days, August, September or October, 1982. A seventh approved program offered by Schaumburg Travel Service will be an Innsbruck Ski Holiday, 10 days, 1982.
- Agreed to request the Chicago Medical Society to allocate space on the 1982 Midwest Clinical Conference schedule for a half-day sports medicine program developed by the ISMS Sports Medicine Committee.
- Authorized the Sports Medicine Committee to develop for Board consideration an Outstanding Team Physician Awards Program to alert the membership to the need for team physicians.
- Voted to direct the ISMS Insurance Plans broker/administrator, Corroon and Black, to develop for promotion to the membership programs and services geared to estate planning.

IDPA DRUG MANUAL

The Board agreed to recommend the following drugs for inclusion in the IDPA Drug Manual: Rid, Li-Ban Spray, Spectrobid, Albuterol Inhalor (cross-indexed under Proventil and Ventolin), Nubain, Ludiomil, Cinobac and Capoten.

LEGISLATION

The Board: (1) Adopted a series of recommendations by the Society's Governmental Affairs Council on legislation still pending before the Illinois General Assembly; and (2) Rescinded the Society's "moratorium" on all new health licensure, agreeing to evaluate any licensure proposal on its own merits.

CME

Addressing a request for input from the Accreditation Council for CME, the Board agreed to recommend that: (1) State associations should be solely responsible for setting policy on accreditation for sponsors within their jurisdictions within standards adopted by ACCME; and (2) Appeals from adverse accreditation decisions should remain at the state level. ACCME had recommended a national mechanism for appeal from state decisions regarding intrastate accreditation. The Board also approved a set of guidelines for selecting directors of the Illinois Council on Continuing Medical Education.

POLICY REVISIONS

The Board will: (1) Submit to the House of Delegates a resolution to amend ISMS policy on "Legislation"; and (2) Ask the House to establish a policy on active medical psychiatric treatment of mental disability and delete current policy on appointments to House reference committees. A minor editorial change in the Society's policy on immunization programs was approved by the Board.

The following policy statements were approved by the Board for addition to the policy manual based upon actions of the House of Delegates at its 1981 meeting.

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered to be a surgical procedure.

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.

GOALS

ISMS councils and committees were directed by the Board to develop proposals for initiation of selected activities designed to accomplish the 1981-82 goals adopted by the Board at its previous meeting. All suggested activities proposed for increasing membership will be considered, as will one priority activity relating to each additional goal. Proposals for implementation are to be developed as initial efforts are completed.

FINANCIAL/ADMINISTRATIVE MATTERS

The Board adopted a revised budget anticipating income of $2,613,111 and expenses of $2,605,068. The resulting $8,043 surplus replaced a $7,000 deficit projected at the beginning of the fiscal year.

In addition, the Board ratified purchase of a word processing unit for use by ISMIS and authorized purchase of a similar unit for the Society, contingent upon budgetary considerations.

It also authorized engagement of financial consulting services to accomplish the following:

- Review of financial accounting and reporting activities to assess their adequacy, strengths and weaknesses and to make recommendations for improvements.
- Review of ISMS financial statements as of June 30. The mid-year examination was viewed as a routine matter necessitated by the resignation of the ISMS business manager/ISMIS Comptroller.
- Executive search service to locate a qualified ISMS business manager/ISMIS comptroller.
- Financial consulting services to oversee the day-to-day business and finance activities until a replacement is selected.

The estimated $50,000 cost for these consulting services will be apportioned equitably between ISMS and ISMIS.

The Board also: (A) Authorized legal counsel and Peat, Marwick & Mitchell to evaluate the existing shared services financial arrangement that exists between ISMS and the Illinois State Insurance Services, Inc.; and (B) Authorized Corroon and Black, Inc. to review and evaluate the Employees' Retirement Program.

OTHER ACTIONS

In other actions, the Board:

- Established a Task Force on Financial Aid to Medical Students to explore development of funds for the creation of scholarships and/or financial grants to students in Illinois medical schools. Appointed to the Task Force were: *Drs. Fred Z. White,* Chillicothe; *Eugene P. Johnson,* Casey; and *Robert P. Johnson,* Springfield, with representatives from medical schools and other members remaining to be selected.
- Directed the Society's Medical Legal and Governmental Affairs Councils to review each of the governmental agencies to which ISMS nominates physicians for appointment and seek legislation in the next General Assembly to grant immunity to physicians serving in those capacities.
- Reaffirmed its recognition of Illinois Cooperative Health Data Systems as a health data resource, and voted to encourage ICHDS to remain active. It was agreed that, in the event PSROs and HSAs are discontinued as data collection sources, ICHDS already would be in place to function as a health data resource.
- Endorsed IDPH efforts in collecting data for use in evaluating emergency medical services.

APPOINTMENTS

Several hundred ISMS members were appointed to one-year terms on the Society's councils and committees for 1981-82. Council chairmen appointed were: *Drs. Robert C. Muehrcke,* Oak Park, Affiliate Societies; *Ronald G. Welch,* Belleville, Economics; *Boyd McCracken,* Greenville, Education and Manpower; *P. John Seward,* Rockford, Governmental Affairs; *Donald Aaronson,* Chicago, Medical Legal; *Joan Cummings,* Hines, Medical Services; *Jerome Beigler,* Chicago, Mental Health and Addiction; and *Peter Vinciguerra,* Libertyville, Public Relations and Membership Services.

Appointed chairmen of those committees reporting directly to the Board of Trustees were: *Drs. Robert A. Behmer,* Rockford, CME Accreditation; *Charles A. Beck,* Chicago, Drugs & Therapeutics; *Andrew Brislen,* Chicago, Health Data; *Samuel L. Andelman,* Chicago, Health Planning; *Gerald S. Modjeska,* Chicago, Insurance; *Alfred Clementi,* Arlington Heights, Loss Prevention Education; *George J. Gertz,* Chicago, Peer Review Appeals; and *Cyril C. Wiggishoff,* Chicago, Planning & Priorities.

NOMINATIONS TO STATE BODIES

The Board nominated the following physicians for appointment to Illinois Department of Public Health and Department of Registration and Education committees:

- *Drs. Robert A. Nachtwey* and *David L. Spencer,* Springfield—IDPH Long Term Care Advisory Committee
- *Dr. Eli Borkon,* Carbondale—IDRE Medical Disciplinary Board
- *Dr. Harry A. Springer,* Chicago—IDRE Board for Opinions on Professional Nursing

It also proposed the following physicians for appointment to the IDPH Perinatal Advisory Committee: *Drs. Silvio Aladjem,* Chicago; *Kofi Amankwah,* Springfield; *George Dohrmann,* Chicago; *William Gottschalk,* Chicago; *William Hamilton,* Carbondale; *Robert Hartman,* Jacksonville; *John Holland,* Springfield; *James Laidlaw,* Champaign; *Carl Mattioda,* Streator; *John McLaughlin, Jr.,* Joliet; *Tim Miller,* Peoria.

Drs. J. Roger Powell, Urbana; *Peter Pleotis,* Arlington Heights; *Benjamin Robbins,* Urbana; *Luis Ruiz-Restrepo,* Urbana; *Arthur Smith,* O'Fallon; *John Standard,* Springfield; *Gerald Staub,* Rockford; *Donald Sherline,* Northbrook; *Darrell Statzer,* Decatur; and *Richard Yoder,* Alton.

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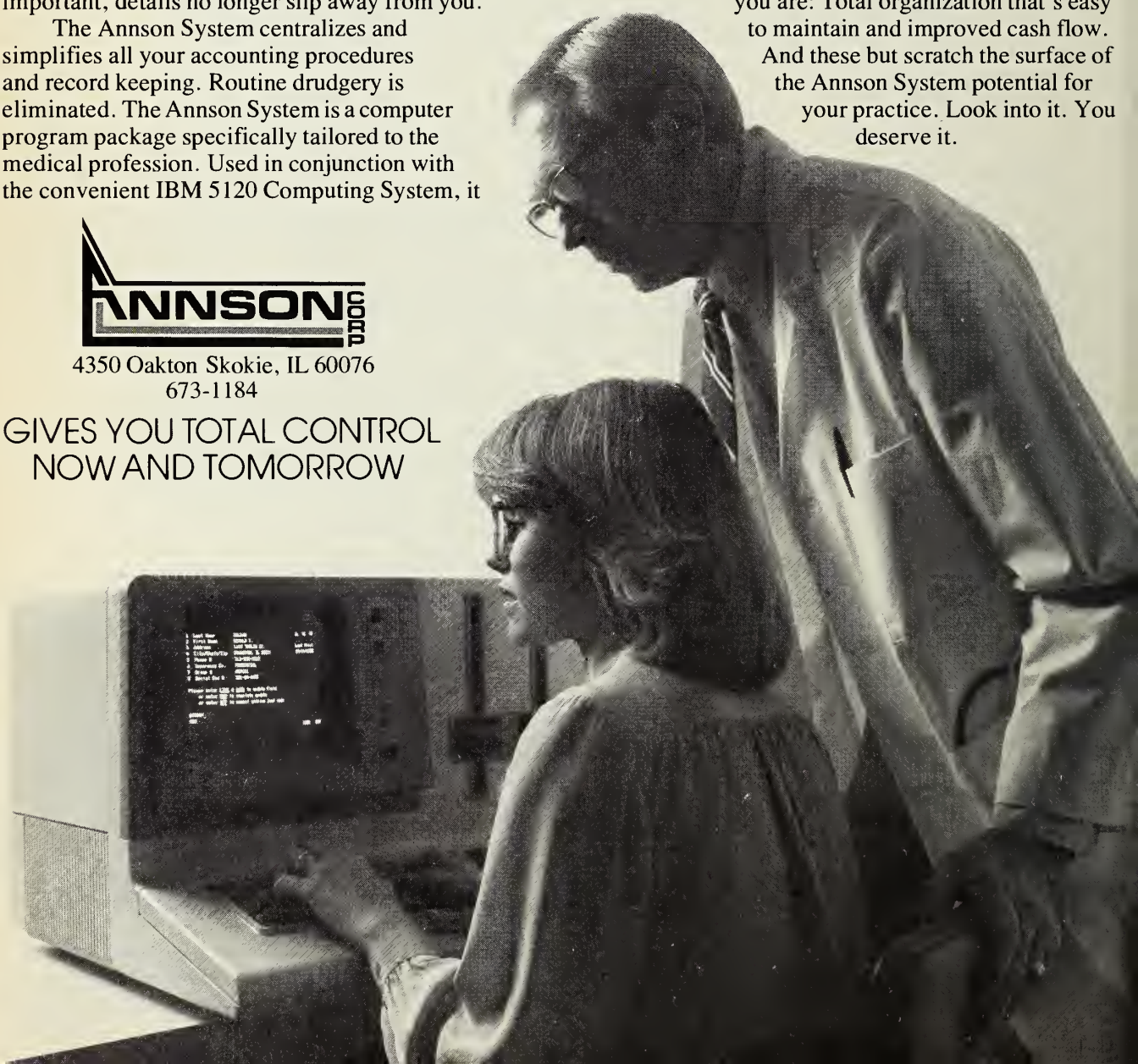
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wn is an artist's representation of a n neuron with the recently discov- d binding site for benzodiazepines. ew theory[1] explains the role of zodiazepines in anxiety man- ment. It also suggests that if a dly eliminated drug is suddenly drawn, it may provoke neuronal erexcitability possibly experi- ed by some patients as "with- wal symptoms." In contrast, a g-acting benzodiazepine gives system more time to adapt by appearing slowly. Thus, distress ermination may be minimized.

tarts promptly*

ANXENE starts to work fast, n pharmacologic effects erved in about 30 minutes. al euphoria is rarely a problem, here's less risk of reinforcing g-taking behavior.[2]

ion reported in normal volunteers 30 minutes losing, *TRANXENE Drug Monograph* 97-0185, p 9.

ation kinetics of an agent can be closely de- but cannot at present be related to therapeutic erse effects.

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For references and a brief summary of prescribing information, please see accompanying column.

Doctor's News

PHYSICIANS IN THE NEWS—**Ronald P. Pawl, M.D.,** Lake Forest, has been elected president of the Chicago Neurological Society and secretary-treasurer of the Midwest Pain Society. Dr. Pawl is an attending neurosurgeon at the Illinois Masonic Medical Center in Chicago. . . . **Ann Garcelon, M.D.,** Chicago, is the 1981 recipient of the Illinois Society of Internal Medicine Norris L. Brookens Memorial Award. A third-year resident at Cook County Hospital, Dr. Garcelon is former assistant director, Illinois Office of Education department of bilingual education and also former director of migrant education and health services in McHenry County. The Brookens award, which includes a plaque, gift and American Society of Internal Medicine membership status, is given each year in honor of outstanding achievement, quality medical standards and unique individualism.

Hugo Long, M.D., Chicago Heights, is a recent recipient of the Abbott Laboratories Golden Hour Clock award, which commemorates 50 years of outstanding service.... **Maurice Lev, M.D.,** Chicago, will present the Simon Rodbard Memorial Lecture at the October meeting of the American College of Chest Physicians in San Francisco. Dr. Lev is one of five physicians selected for special recognition at the 47th annual ACCP scientific assembly.

M. Eugene Tardy, M.D., J.D., Chicago, has been chosen president-elect of the American Academy of Facial Plastic and Reconstructive Surgery. Dr. Tardy is director of the division of plastic and reconstructive surgery, department of otolaryngology, UI Medical Center. . . . **Charles L. Swarts, M.D.,** Oak Park, has been named chairman of the Intergency Council on Smoking and Disease. The ISMS representative to that Council, Dr. Swarts will also serve as chairman of the adult education committee. (The Interagency Council supplies lists of "I Quit," smoking clinics which are published bimonthly in the *Journal.*

REFERENCE ISSUE DELAYED—The annual *IMJ* Reference Issue, ordinarily published in October, will be published in November this year, in order to accommodate current organizational information.

TELEPHONE INSTRUCTION—The AMA has published a new brochure, entitled "Handling Patient Telephone Calls Effectively," designed for training new medical office receptionists and providing a quick review for experienced staff. The publication includes a cassette tape and worksheets, and demonstrates methods to respond to calls for medical information or advice, calls from irate patients and emergencies. Copies may be obtained at a cost of $17 by writing the AMA Order Dept., OP-081, P.O. Box 821, Monroe, Wisconsin 53566.

QUIT SMOKING MANUAL AVAILABLE—The Chicago Lung Association has developed a self-help guide for persons who want to quit smoking without attending clinics or support groups. They report initial test results showing a strong success rate. Copies of the "Freedom From Smoking" guide, or further information may be obtained from the Chicago Lung Association, 1440 W. Washington Blvd., Chicago IL 60607; (312) 243-2000, ext. 64, 66. A $5.00 contribution to the Lung Association is requested to cover printing and handling costs.

Viewbox

(Continued from page 216)

DIAGNOSES:

Patient 1: Meconium plug syndrome
Patient 2: Anorectal malformation (imperforate anus)
Patient 3: Hirschsprung's disease.

Figure 1 shows a plug of meconium in the distal colon, outlined by barium. The gas filled small bowel is dilated. The patient evacuated a large amount of meconium and had no further difficulty. In figure 2, a lower bowel obstruction is demonstrated on the plain film. The urethrogram opacifies a fistula from the posterior urethra to the colon. Figures 3A and 3B show a narrowed distal sigmoid and rectum with dilatation proximally. Irregular contraction of the aganglionic segment is demonstrated. Additionally, there is mucosal thickening proximally due to enterocolitis.

TABLE 1

Neonatal Bowel Obstruction: Colonic Causes

Several disease entities involving the colon can present with obstruction in the neonatal period.[1-3]

- Hirschsprung's Disease
- Functional obstruction of the neonate (meconium plug, small left colon)
- Stricture secondary to necrotizing enterocolitis
- Atresia
- Duplication
- Leiomyosarcoma
- Hydrocolpos
- Anorectal malformation

Of the causes of neonatal colonic obstruction, *Hirschsprung's Disease* is the most common, with involvement in 1/5000 live births, of which 80% are male.[2,4] The etiology consists of an absence of intramural colonic ganglion cells due to arrest of the caudal migration of neuroblasts.[4] The aganglionic segment begins at the anus and extends for a variable distance proximally, most commonly to the rectosigmoid, but sometimes into the entire colon and small bowel.

In most cases symptoms occur in the first week of life.[2] Physical signs include abdominal distention with bilious vomiting. It is important to make the diagnosis early, as the incidence of complications increases with delay.[2,4]

Plain films reveal a nonspecific low bowel obstruction with few air fluid levels. An opaque

(Continued on page 266)

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*Data on file Parke-Davis Marketing Research Dept.
**Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1980. The *National Prescription Audit*, IMS America Ltd., September 1980.

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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.
Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.
Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues. These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling.
The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions.
Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.
Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.
Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.
Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.
Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.
Prolonged or excessive use of corticosteroids might produce systemic effects.
If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.
In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.
Anusol-HC is not for ophthalmic use.
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See "WARNINGS"
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Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.
Dosage and Administration: Anusol-HC Suppositories–
Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.
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Viewbox

(Continued from page 265)

enema should be performed in the unprepped patient to enhance the chances of demonstrating a transition zone.[2,3] It is important to prepare the barium mixture with saline to avoid the complication of water intoxication due to absorption of large amounts of water in the dilated proximal colon. The classic finding is that of a transition zone from the normal to the aganglionic segment (distally). The rectum is typically normal to reduced caliber with dilatation proximally.[2] This finding, however, is often absent in the neonatal period.[5] If the transition zone is demonstrated, the exam should be terminated. Other findings on the enema include abnormal contraction of the aganglionic segment and lack of distensibility of the rectum.[3] When suspecting Hirschsprung's, 24 to 48 hour delay films should be obtained, as retained barium may be seen. This finding in itself is not diagnostic, as retained barium may also be seen in functional immaturity of the colon. Patients with Hirschsprung's may even have a normal BE initially. The radiological findings should be correlated with manometric studies and punch biopsy. Some feel that a punch biopsy of the colon is needed even if the BE is characteristic, as there can be a transition zone in other conditions (congenital hypothyroidism, meconium plug, and infants of diabetic mothers).[4]

Complications of Hirschsprung's Disease include enterocolitis and perforation. Prompt colostomy is needed, with definitive surgery delayed until about one year of age.[2]

Total colonic Hirschsprung's, which comprises about 10% of all Hirschsprung's, shows findings that are somewhat different. On BE the caliber of the colon can be enlarged with shortening of the colon and incomplete small bowel obstruction. There can be massive reflux of barium into the small bowel.[2]

Functional obstruction of the neonate can be caused by meconium plugs, small left colon, and transient obstruction of the premature infant. These entities are all manifestations of the spectrum of functional immaturity of the colon.[5] This entity is more common in the infant of the diabetic mother.

Patients present clinically with failure to evacuate meconium, abdominal distention, and bilious vomiting.[3] On plain films there is mild to moderate distention of bowel loops and few if any air fluid levels. On enema there are findings of a microcolon localized to the sigmoid and

descending colon with proximal distention and change in caliber at the area of the splenic flexure. A plug of meconium may or may not be present. The colonic appearance returns to normal quickly following evacuation. There can be retention of barium on the 24 hour delayed film.[3]

Differentiating points from Hirschsprung's disease include the age of the infant, with prematurity suggesting functional immaturity. Change of caliber at the splenic flexure is more common in functional immaturity.[3] Marked dilatation of the colon and small bowel with air fluid levels is more suggestive of Hirschsprung's.

Functional immaturity of the colon cannot be diagnosed on the basis of the BE alone. A sweat test should be performed to rule out cystic fibrosis which can cause a similar pattern.[3] Some patients will have an appearance of meconium plugs on BE with improvement clinically after the BE for a time, with later recurrence of symptoms. These patients later are found to have Hirschsprung's Disease. Thus, continued follow-up of the infant is necessary.

Anorectal malformations occur in 1/5000 live births with a slight predominance in males. In the workup of this problem it is important to ascertain if the rectum terminates above or below the pelvic musculature, as this determines the operative approach.[2] Fistulas are a frequent association (rectourethral, rectovesical, rectovaginal, rectoperitoneal, etc.).

For years an inverted lateral view of the rectum has been advocated for differentiating high and low lesions. Several errors are inherent in this view and limit its value. A low lesion may look high if there is termination of rectal gas because of meconium in the distal rectum or failure of gas to reach the rectum. Also, with increased abdominal pressure, the lesion may look lower than it really is.[2] Cystourethrograms are performed by some to help delineate the fistulas. Associated findings include sacral and lumbar spine anomalies and renal malformations. Plain film radiographic findings are nonspecific and are those of a lower bowel obstruction. ◀

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IMJ Attention

ERRATUM — A story in the September *IMJ* Attention included a misleading statement in a story devoted to anticipated effects of new HHS requirements for PSRO performance assessment. We stated that the HHS criteria would "assist HHS in terminating up to 30% of established PSROs by May, 1981." That somewhat confusing statement should have said that the criteria would assist HHS in terminating up to 30% of PSROs functioning in May, 1981 (including those terminated as of September, 1981) by September, 1982. We apologize.

PHYSICIAN SERVICES AND THE CPI — The federal government's Consumer Price Index for July showed that physician services rose 1.1% during that month, while the CPI as a whole increased by the same amount. The all-services category of the CPI rose by 1.7% during July, while the medical care category increased by 1.4%. (The medical care category includes physician services, dental services, hospital room charges and prescription drugs.)

AMA notes that charges for physician services have increased by 11% over the past 12 months, while the CPI as a whole has risen by 10.7% and all-services category rose by 13.4%. During that same period, hospital room charges increased by 14.3%, prescription drugs by 11.6% and dental services by 10.5%.

JCAH STANDARDS TO BE REWRITTEN — The Joint Commission on Accreditation of Hospitals (JCAH) plans to rewrite their standards on the bases of specific principles and a new format. The JCAH Board of Commissioners has also announced that the revised standards will "state objectives to be met and leave the mechanism for achieving their intent to the discretion of the individual hospitals. All standards will be reasonable and surveyable, reflecting the consensus of the current state of the art." It is expected that the revised standards will be clarified, simplified and shortened.

LEGISLATION SIMPLIFIES PRESCRIPTION FORMS — Legislation allowing modification of prescription forms to simplify the process of drug product substitution (DPS), was signed recently by Governor Thompson. The law—SB 211—requires the physician to sign the form in his own handwriting to authorize issuance of the prescription. Newly-printed prescription forms will only be required to have a single signature line along with two boxes accompanied by the printed words, "MAY SUBSTITUTE" or "MAY NOT SUBSTITUTE." The new law does not specify order or location of these choices.

The physician is required to place a mark beside the "MAY SUBSTITUTE" or "MAY NOT SUBSTITUTE" alternatives. Failure to place a mark beside the "MAY NOT SUBSTITUE" alternative will authorize generic interchange. Furthermore, the new statutory language prohibits preprinted or rubber-stamped marks beside either selection.

Current prescription forms are adequate and legal until the physician's supply is exhausted, as long as the physician conforms to the original provision requiring a signature on the chosen line and checking the correct box.

The new law—to which ISMS offered key amendments—was developed by the Illinois Department of Public Health to eliminate much of the confusion resulting from a 1977 law designed to encourage drug substitution.

TRAVEL PROGRAMS SCHEDULED FOR '82 — The following ISMS-sponsored travel programs have been scheduled for 1982: Feb. 13-22-Ski Holiday in Innsbruck; March 6-13-Mexican Riviera on the Love Boat; May 15-25-Nile River Cruise; Aug. 24-Sept. 2-Canadian Rockies Adventure.

Reservations cannot be accepted unless they are submitted on the official form printed in promotional brochures which are mailed to all ISMS and Auxiliary members. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by the tour operator. Contact ISMS headquarters for additional information.

REGIONAL LOSS PREVENTION PROGRAMS SCHEDULED — The ISMS Loss Prevention Education Committee has developed three regionalized all-day programs to help physicians minimize their chances of being sued. The programs will supplement the current two-hour programs being presented to to hospital medical staffs and county medical societies throughout the state. Each program will offer seven hours of Category 1 CME credit. Registration, which is limited, will be $50 for ISMS members and $200 for nonmembers. All programs will be presented on Saturday as follows: November 14, Springfield; February 6, Belleville; and April 3, Chicago-area. For information contact the ISMS Loss Prevention Education Committee, (312)-782-1654.

BUDGET CUT BOOMERANG — It is anticipated that elimination of the Social Security minimum benefit will result in higher federal and state Medicaid costs as those recipients become eligible for Supplemental Security Income (SSI). According to a report published by the McGraw-Hill *Washington Report on Medicine and Health*, up to 500,000 persons could be so effected, and while the administration expects that only 25 percent will actually apply for SSI, the Congressional Budget Office has promulgated higher estimates.

In a related matter, McGraw-Hill reports that shortages in the 1981 administrative Medicare budget are expected to cause delays in processing Medicare claims through the fall. The HHS Health Care Financing Administration has indicated, however, that no benefits will be cut to meet the administrative fund shortage.

DNA REGULATIONS — The Recombinant DNA Advisory Committee of the National Institutes of Health has voted to recommend that experiments mixing genes of various organisms should be required to meet only voluntary safety guidelines. According to a story in the McGraw-Hill *Washington Report on Medicine and Health*, all regulatory provisions which affect "gene splicing" research will be dropped if this preliminary action is formally approved.

TRANSPORTING THE INJURED — The AMA Commission on Emergency Medical Services and the U.S. Department of Transportation have jointly produced a set of "Air Ambulance Guidelines," to assist physicians and air ambulance operators in planning air transport of ill or injured persons. Complimentary copies may be obtained by writing the General Service Division, National Highway Traffic Safety Administration, 400 Seventh St. S.W., Washington D.C. 20590

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REPORT FOR *Illinois Physicians*

Tresnowski To Head BC/BSA

Bernard R. Tresnowski has been named president-designate of the Blue Cross and Blue Shield Associations by the Associations' Board of Directors.

Tresnowski, presently executive vice president of the Associations - the national coordinating organizations of the nation's 111 Blue Cross and Blue Shield Plans, will be confirmed as President by the Associations' Board at their annual meeting in November.

The selection of Tresnowski to succeed Walter J. McNerney, who has been President of BCA since 1961 and President of BCA and BSA since 1978, was announced by the Chairman of the Associations' Joint Executive Committee, Marvin J. Shaprio, M.D. of Encino, California, and John B. Morgan, Jr., President of Hospital Care Corporation, Cincinnati, Ohio.

Tresnowski's record of accomplishments as an officer of the Associations and in health care administration prior to that, make him a logical successor to McNerney, who led the Associations with distinction, Shapiro and Morgan said.

Tresnowski, who joined the Blue Cross Association in 1967 as head of its Medicare Administration Division, was named senior vice president of Federal Programs and Health Care Services before becoming executive vice president of BCA in 1977.

When the staffs of the Blue Cross and Blue Shield Associations were consolidated in 1978, he was named executive vice president of both organizations.

Tresnowski succeeds McNerney who announced his resignation as president of BCA and BSA in June. McNerney has announced his specific plans for the future but said that he will soon be selecting one of several alternatives with a view toward meeting new challenges in the health care field.

A graduate of the University of Michigan and the University of Pittsburgh, where he earned his Master of Public Health Degree in Hospital Administration, Tresnowski held research, teaching and administrative posts early in his career.

At the time he joined the Blue Cross Association, Tresnowski was chief executive of the 422-bed St. Joseph Mercy Hospital in Pontiac, Michigan.

Phone Numbers To Change

As part of our continuing effort to improve service, the Illinois Blue Cross and Blue Shield Plan will convert to one of the finest telephone systems available on December 14, 1981. The change only effects our headquarter's building at 233 North Michigan Avenue.

The success of our new telephone system rests heavily on you to use the new telephone numbers listed below on December 14, 1981.

The current '661' exchange will be chaged to '939' and all current extensions also will be changed.

The new Physician Hot-Line number within the '312' area code will be *939-7340*. The toll free number for area codes other than '312' will remain the same (800-972-8088). Please remember that these lines were installed to provide a service to you. Please do not give these numbers to your patients.

The new telephone number for the general public will be *938-7500*.

Your Professional Relations Representative's new telephone numbers on December 14, 1981, will be as follows:

Sandra Konnis	938-7880
Richard Quigley	938-7884
William R. Livingston	938-7885
Professional Relations Department	939-7060

REMEMBER: The new Physician Hot-Line number within '312' area code will be *938-7340* as of December 14, 1981.

Changes Made in State Employees Health Program

The Ambulatory Surgical Program for State Employees was published in the July issue of the Illinois Medical Journal. A list of surgical procedures was reported to you that would not be in benefit if the procedures were performed as a hospital in-patient unless the doctor provided medical reasons why the surgery had to be done as in-patient surgery. Since July, we have had discussions regarding the procedures on the list and the State of Illinois representatives concur with our decision to make the folllowing changes:

Deleted from the List:

1. *Liver Needle Biopsy*
2. *Kidney Needle Biopsy*
3. *Carpel Tunnel*
4. *Lumbar Puncture*
5. *Morton's Neuroma*

Language Revision and/or Clarification:

1. Digit amputation has been changed to "revision of" digit amputation.
2. Foreign body removal has been changed to removal of unnatural material from hand or foot.
3. Laceration, suture of skin and tendon has been changed to laceration, suture of skin.
4. Pin and screw removals- has been changed to pin and screw removal from hand or forearm.

The following ammended list is made up of the most common elective surgical procedures which the surgical community agrees frequently can be performed in an ambulatory setting. Payment will not be made for these procedures unless the doctor provides medical reasons why the surgery had to be done as an in-patient. The reasons should be attached to the Blue Shield claim form at the time the claim is submitted.

Addominal paracentesis
Antrum irrigations
Arthrocentesis
Arthrography and arthroscopy
Aspiration of Douglas's cul-de-sac
Bartholin cyst excision, marsupializationor I&D
Bladder puncture aspiration
Blepharoplasty, non-cosmetic
Breast biopsy
Bronchoscopy with or without biopsy
Cervical biopsies or polypectomies
Circumcision male
Closed reduction of complete dislocations or fractures
Culdoscopy with or without biopsy
Cyst aspiration
Cystogram
Cystoscopy with or without retrograde pyelogram
Digit amputation, revision of
D&C, diagnostic and therapeutic
Dorsal split of prepuce
Esophageal dilation
EUA (examination under anesthesia)
Excision of soft tissue lesions (nevus, verrucus, epithelioma, scar revision)
Fiberoptic endoscopy with or biopsy
Foreign body removal of unnatural material from hand or foot
Frenulotomy of tongue
Ganglionectomy
Gastroscopy with or without biopsy
Herniorrphapy (up to age 14)
Hydrocelectomy
Hymenectomy
Hysterosalpingography
I&D (incision and drainage of superficial lesions)
Injection of joint, tendon or ligament
IUD insertion and removal, if anesthesia necessary
Laceration, suture of skin
Laparoscopy with or without tubal ligation
Laryngoscopy with or without biopsy
Lipoma removal
Mammoplasty, non-cosmetic
Meatotomy
Minor eyelid procedures
Minor rectal surgery (not under spinal)
Muscle biopsy
Myringotomy
Nasal fracture reduction, open and closed
Nasal Polypectomy
Nerve blocks
Node biopsy (superficial)
Otoplasty, non-cosmetic
Otoscopy with or without biopsy
Pin and screw removals from hand or forearm
Proctosigmoidoscopy with or without biopsy
Skin biopsy
Skin graft (small)
Submucus resection of nasal septum
Synovial cyst removal
Tear duct probing
Thoracentesis for fluid aspiration
Trigger finger
Triple upper endoscopy
Urethral dilation
Variocelectomy
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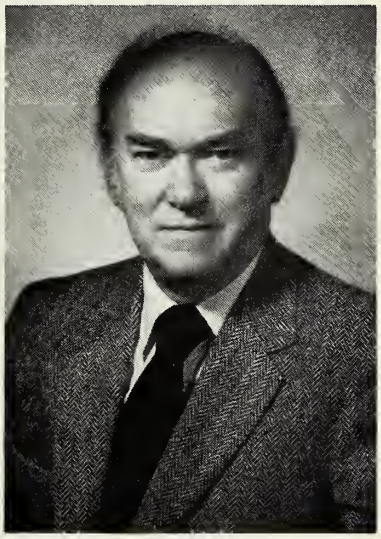
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7531 Stony Island, Chicago 60649

President's Page

Nobody's Perfeckt



When judging others, we sometimes make a decision on the basis of a single act. For that particular act, our judgment may be appropriate, but it could be an incorrect assessment when viewed from a wider perspective.

This is especially true of legislators who make multiple decisions on a variety of issues. Often, they act in ways that are favorable to physicians and medicine. Occasionally, however, their actions conflict with our individual beliefs and philosophies.

To condemn a legislator, or even to chide him gently, because of a single decision which is contrary to our point of view, is not likely to change that opinion. And in the long run, it may prove counterproductive to our future efforts.

Negative comments are not a means of reaching our objectives of educating and influencing legislative and state department decision makers. A critical or negative remark or letter to a legislator may well turn him from our point of view at a future time. It is far better to positively reinforce the judgments and actions with which we concur and remain silent on those with which we disagree.

When there is a question or doubt as to the reason for a particular legislator's position, the wise course is to discuss the matter with the ISMS Governmental Affairs Division or with one of the legislative Key Men in the district. This decision may yield some insights into the political process and could prevent a precipitous action which could turn a friendly legislator away from us.

Most lawmakers and other individuals within state and federal government must make many decisions on a wide array of issues. Those issues involving medicine actually are relatively few in number. And while they are of critical importance to us, they probably are of much lesser import to them.

Therefore, we should remember first to consider our overall objectives. Next, we should remember that we have staff and physician members who are knowledgeable in this area and are most able and willing to help. And finally, we must remember that nobody is perfeckt. ◀

Fred Z. White, M.D., President

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Statement of Ownership
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8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities (if there are none, so state): None.

9. For Completion by Nonprofit Organizations Authorized to Mail at Special Rates (Section 411.3 DMM only) The purpose, function, and nonprofit status of this organization and the exempt status for Federal income tax purposes have not changed during the preceding 12 months.

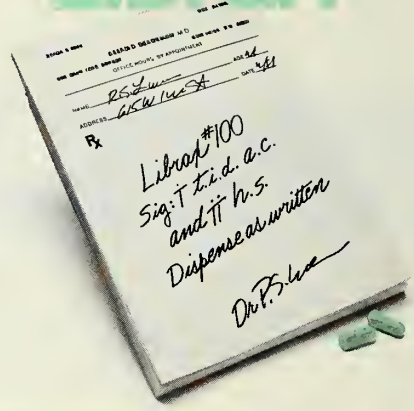
10. Extent and Nature of Circulation.

	Average no. copies each issue during preceding 12 months	Actual no. of copies of single issue published nearest to filing date
A. Total No. copies printed (net press run)	16,183	16,100
B. Paid Circulation		
1. Sales through dealers and carriers, street vendors and counter sales	225	225
2. Mail subscriptions	14,784	14,795
C. Total paid circulation (sum of 10B1 and 10B2)	15,009	15,020
D. Free distribution by mail, carrier or other means, samples, complimentary, and other free copies	980	943
E. Total distribution (sum of C and D)	15,989	15,963
F. Copies not distributed		
1. Office use, left over, unaccounted, spoiled after printing	194	137
2. Returns from news agents	None	None
G. Total (Sum of E, F1 and 2—should equal net press run shown in A)	16,183	16,100

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Richard A. Ott, Managing Editor

Specify Librax®



Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.
Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.**

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br

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ing information on facing page

ograph of simulated gastric hypersecretion

Abstracts of Action

September 26, 1981 **Chicago**

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

ANNUAL MEETING

The Board approved a shortened meeting schedule for the House of Delegates' 1982 Annual Meeting. The meeting will be held Friday-Sunday, April 16-18, with a Board of Trustees meeting on Thursday, April 15. The location of the meeting will be announced at a future date.

UTILIZATION REVIEW PROGRAMS

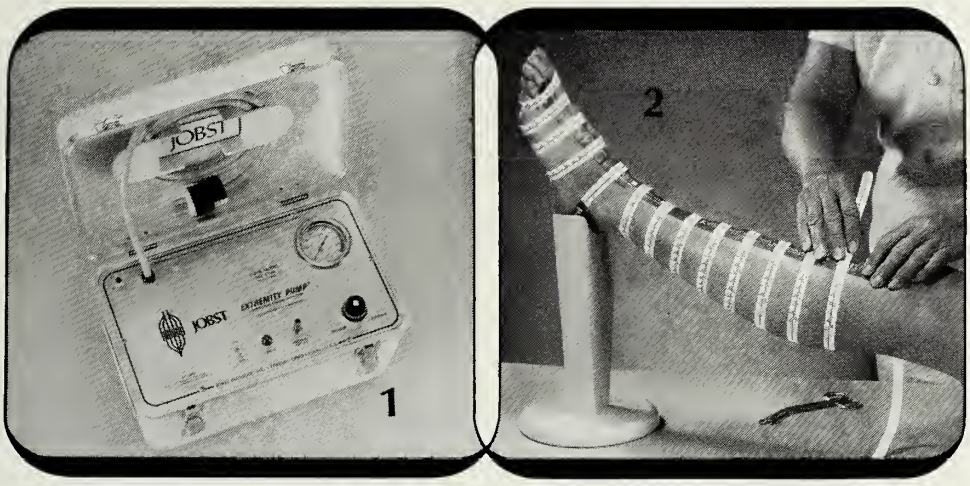
Acting upon the recommendation of an ad hoc committee to study utilization review programs, the Board agreed to submit a proposed position paper and companion resolutions to the House of Delegates for consideration at its Interim Session. Feature points of the position paper include:

1. Purchasers of health care services will require accountability, and that this accountability should be accomplished through UR.
2. UR will include inpatient and long-term care, and, ultimately, may expand to include the review of ambulatory services.
3. UR may be delegated by organizations designed and sponsored by physicians to qualified hospital UR committees.
4. An appeal mechanism should be established within the structure of ISMS to resolve disputed UR decisions.

The proposal would call upon ISMS to investigate the feasibility of becoming a statewide support center for physician review organizations, soliciting the endorsement of local societies and foundations to provide administrative support, data processing and specialized services to local groups.

One of the resolutions to be submitted to the House will echo present AMA policy, proclaiming ISMS support for "physician assessment of the quality of medical care regardless of the future fate of PSROs." The resolution would urge physicians to "maintain control and direction over peer review, regardless of what mechanisms evolve for peer review and over public or private funds that are directed to such activities." A second resolution is more specific in that it directs the Board to "prepare a report on the future of ISMS' role in UR activities, delineating various alternative approaches available to ISMS . . . (and that the) recommendations contained in the report be brought to the next meeting of the House of Delegates for discussion and action." A third resolution will urge House approval for the proposed position paper.

(Continued on page 377)



Twin Engineering Devices, to Reduce Massive Lymphedema, and Maintain the Reduction.

Massive and obstinate lymphedema of the limbs may be reduced through use of the Jobst Extremity Pumps (Intermittent Compression) (photo 1). Its controlled pneumatic massage gently removes edema fluid from congested areas.

Jobst Extremity Pumps are available in hospital, clinical, and home models (shown), the latter being available on rental. All units have controls to vary both pressure and time cycles.

When the desired reduction is attained, it can be maintained with a *Jobst Venous Pressure Gradient®* Support. These supports are custom-made to your prescription and the patient's individual measurements (photo 2). You may prescribe exact counterpressures. "In-Patient" orders will be given special attention.

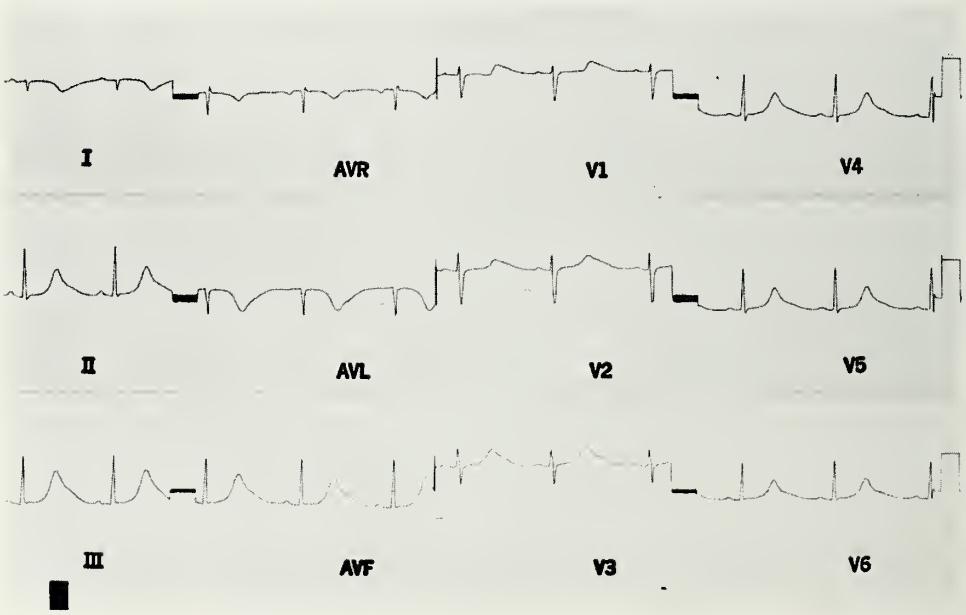
Contact your local Jobst Service Center for complete details.

JOBST SERVICE CENTER
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Pittsfield Bldg.
55 E. Washington Street
Chicago, Illinois 60602
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EKG of the Month

Contributing Editors: John F. Moran, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This patient is a twenty-nine year old lady with a recent history of labile hypertension. She came to the emergency room because of a severe headache associated with nausea and vomiting. She was also somewhat confused and required family assistance to answer questions. She denied any recent trauma. A complete blood count and chest X-ray were normal. A twelve lead ECG was obtained because of a slow pulse rate.



Questions:

1. The ECG shows:

a. An acute myocardial infarction.
b. Left bundle branch block.
c. Marked non-specific or non-diagnostic ST-T wave changes.
d. A prolonged Q-T interval.
e. A slow junctional rhythm.

2. The following statement(s) is/are true:

a. The most likely diagnosis here is asymptomatic acute subendocardial infarction.
b. The most likely diagnosis here is acute spontaneous intracranial hemorrhage.
c. The most important predisposing factor in cerebral vascular accidents is hypertension.
d. An aneurysm of the cerebral vasculature can occur at any age although middle age is the most common time for rupture.
e. All of the above.

(Continued on page 401)

ew basis for nderstanding anxiety ggests new reasons r choosing anxene © IV 4306CB

zepate dipotassium



n is an artist's representation of a neuron with the recently discov- inding site for benzodiazepines. theory[1] explains the role of diazepines in anxiety man- ent. It also suggests that if a eliminated drug is suddenly awn, it may provoke neuronal excitability possibly experi- by some patients as "with- l symptoms." In contrast, a cting benzodiazepine gives stem more time to adapt by earing slowly. Thus, distress mination may be minimized.

rts promptly*

XENE starts to work fast, harmacologic effects ed in about 30 minutes. euphoria is rarely a problem, e's less risk of reinforcing aking behavior.[2]

eported in normal volunteers 30 minutes g, *TRANXENE Drug Monograph* 97-0185,

kinetics of an agent can be closely de- annot at present be related to therapeutic effects.

Stops gently**

A long-acting benzodiazepine, such as TRANXENE, has a kind of built-in tapering-off action; withdrawal reactions when they occur may be subtle, of longer duration and much attenuated.[3]

Works smoothly

TRANXENE works short-term — studies show dependable, smooth calming action with 83% to 90% overall therapeutic response.[4] Oversedation is seldom seen and the incidence of serious side effects has been low.

For references and a brief summary of prescribing information, please see accompanying column.

When short-term therapy is indicated...

Tranxene (IV)
clorazepate dipotassium

INDICATIONS — For management of anxiety disorders or short-term relief of symptoms of anxiety; for symptomatic relief of acute alcohol withdrawal; for adjunctive therapy in partial seizures.

Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic. Effectiveness in long-term management of anxiety (over 4 months) not assessed by systematic clinical studies. The physician should periodically reassess usefulness for each patient.

CONTRAINDICATIONS — Known hypersensitivity to the drug. Acute narrow angle glaucoma.

WARNINGS — Not for use in depressive neuroses or psychotic reactions. Caution patients against hazardous occupations requiring mental alertness, such as operating dangerous machinery including motor vehicles. Advise against simultaneous use of other CNS depressants, and caution patients that effects of alcohol may be increased. Not recommended for patients under 9. Nervousness, insomnia, irritability, diarrhea, muscle aches, and memory impairment have followed abrupt withdrawal from long-term high dosage. Withdrawal symptoms were reported after abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months. Use caution in patients having psychological potential for drug dependence (dependence has been observed in dogs and rabbits).

Pregnancy and Lactation: Minor tranquilizers should almost always be avoided first trimester. Consider possibility of pregnancy before initiating therapy. Patient should consult physician about discontinuation if she becomes pregnant or plans pregnancy. Do not give to nursing mothers.

PRECAUTIONS — Observe usual precautions in depression accompanying anxiety, or in patients with suicidal tendency, or those with impaired renal or hepatic function. Do periodic blood counts and liver function tests during prolonged therapy. Use small doses and gradual increments in the elderly or debilitated.

ADVERSE REACTIONS — Drowsiness, dizziness, various g.i. complaints, nervousness, blurred vision, dry mouth, headache, mental confusion, insomnia, transient skin rashes, fatigue, ataxia, genitourinary complaints, irritability, diplopia, depression, slurred speech, abnormal liver and kidney function, decreased hematocrit, decreased systolic blood pressure.

INTERACTIONS — Potentiation may occur with ethyl alcohol, hypnotics, barbiturates, narcotics, phenothiazines, MAO inhibitors, other antidepressants. In bioavailability studies with normal subjects, concurrent administration of antacids at therapeutic levels did not significantly influence bioavailability of TRANXENE.

OVERDOSAGE — Take general measures as for any CNS depressant.

SUPPLIED — TRANXENE 3.75, 7.5, and 15 mg capsules and scored tablets. TRANXENE-SD Half Strength 11.25 and TRANXENE-SD 22.5 mg single dose tablets.

REFERENCES — 1. Snyder SH: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 6–7. 2. Mielke DH, Goethe JW: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 31. 3. Hollister LE: *Anxiety: The Therapeutic Dilemma*, No. 2, Management Alternatives, Monograph 97-0544, 1981, p 13. 4. *TRANXENE Drug Monograph* 97-0185, 1981, p 15.

Abbott Pharmaceuticals, Inc.
North Chicago, IL 60064

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Clinics for Crippled Children Listed for December

Forty clinics for Illinois' physically handicapped children have been scheduled for December by the University of Illinois, Division of Services for Crippled Children. The clinics provide diagnostic orthopedic, pediatric, speech and hearing examination, along with medical, social and nursing services. There will be 28 general clinics, 10 cardiac clinics, one for children with neurological problems and one for children with myelodysplasia. Any private physician may refer to or bring to a convenient clinic any child or children for whom he may want examination or consultative services.

1 Maryville - Oliver C. Anderson Hospital
1 Park Ridge Cardiac - AM - Lutheran General Hospital
1 Park Ridge General - PM - Lutheran General Hospital
1 Wheaton General - Marianjoy Rehab. Hosp.
2 Carmi - Carmi Township Hospital
2 Hinsdale - Hinsdale Sanitarium
3 Sterling - Community General Hospital
3 Litchfield - St. Francis Hospital
3 Lake County Cardiac - Victory Mem. Hosp.
4 Division Cardiac - U. of I. at the Medical Center
7 Peoria Myelodysplasia - St. Francis Medical Center
8 East St. Louis - Community Hospital
8 Peoria - St. Francis Medical Center
9 Rockford - St. Anthony Hospital
9 Rock Island CP - Foundation for Crippled Children & Adults
9 Champaign-Urbana - McKinley Health Service Center
9 Chicago Heights General - St. James Hosp.
9 Joliet - St. Joseph's Hospital
10 Springfield General - St. John's Hospital
10 West Frankfort - United Mine Worker's of America - Union Hospital
10 Aurora Cardiac - Mercy Center for Health Care Services
10 Kankakee General - St. Mary's Hospital
14 Peoria Cardiac- St. Francis Medical Center
14 Belleville - Belleville Memorial Hospital
14 Chicago Heights Cardiac - St. James Hosp.
14 Maywood - (Orth/Ped/Neuro) - Loyola Medical Center
15 Rock Island General - Moline Public Hosp.
16 Springfield Ped-Neuro - St. John's Hosp.
16 Aurora General - Mercy Center for Health Care Services
17 Rockford - Rockford Memorial Hospital
17 Anna - Union County Hospital
17 Bloomington - Mennonite Hospital
17 Elmhurst Cardiac - Memorial Hospital of DuPage County
18 Kankakee Cardiac - St. Mary's Hospital
18 Evanston - St. Francis Hospital
21 Chicago Heights Cardiac - St. James Hosp.
21 Maywood - (Orth/Ped) - Loyola Medical Center
23 Chicago Heights General - St. James Hosp.
28 Peoria Cardiac - St. Francis Med. Center
28 Maywood - (Orth) - Loyola Medical Center

The Division of Services for Crippled Children is the official state agency established to provide medical, surgical, corrective and other services and facilities for diagnosis, hospitalization and after-care for children with crippling conditions or who are suffering from conditions that may lead to crippling. In carrying on its program, the Division works cooperatively with local medical societies, hospitals, the Illinois Children's Hospital-School, civic and fraternal clubs, visiting nurse associations, local social and welfare agencies, local chapters of the National Foundation and other interested groups. In all cases, the work of the Division is intended to extend and supplement, not supplant, activities of other agencies, either public or private, state or local, carried on in behalf of crippled children.

The Viewbox

Contributing Editor Terrence Demos, M.D., associate professor of radiology,
Department of Radiology, Loyola University Stritch School of Medicine

This month's Viewbox was submitted by Robert Churchill, M.D. and Carlos Reynes, M.D., Department of Radiology, Loyola University Medical Center, Maywood.

The following sonograms are of four different patients with right upper quadrant abdominal pain. Match each with a diagnosis below.



Figure 1

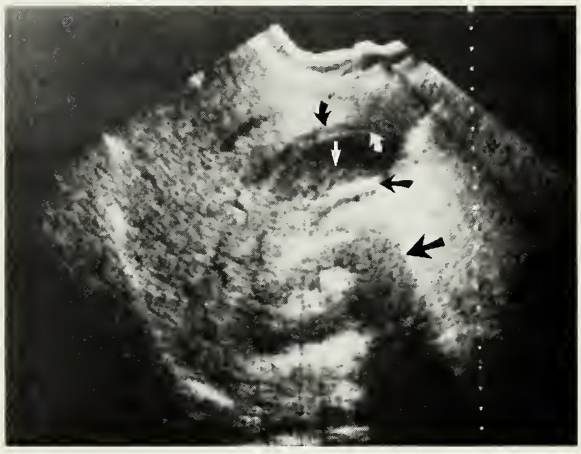


Figure 3



Figure 2

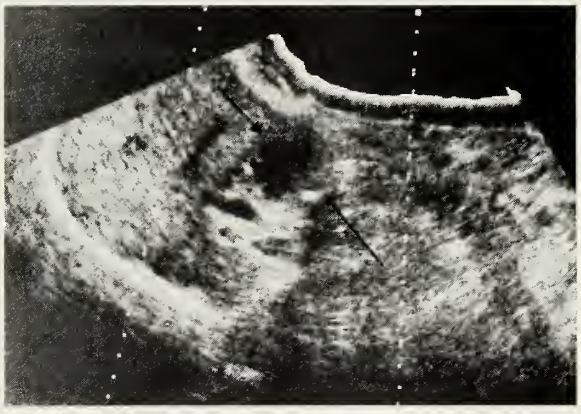


Figure 4

What is your diagnosis?

A. Carcinoma of the gallbladder must be ruled out.
B. Single gallstone with acoustic shadowing.
C. Impacted stone in gallbladder neck causing hydrops with "sludge".
D. Acute cholecystitis, cholelithiasis, and empyema of the gallbladder.

(Continued on page 399)

Now,
when you treat respiratory
tract infections†...

DRIVE MORE ANTIBIOTI



† *Streptococcus pyogenes, Streptococcus pneumoniae,* nonpen… …taphylococci, *Haemophilus influenzae.* Because not all … ns of … …commended that routine culture and susceptibility tests b…

‡ Tissue penetration is regarded as essentia… …icacy, but specific antibiotic tissue levels have not been correlated with specific therapeutic e…

For SPECTROBID® (ampicillin HCl) brief summary of prescribing information, please see last page of advertisement.

IMJ
Illinois Medical Journal
Vol. 160, No. 5, November, 1981

ISMS ORGANIZATION

History of Founding and Expansion

Twenty-nine physicians met in Springfield June 4, 1850, to organize on a permanent basis the Illinois State Medical Society, which had been started informally 10 years earlier. The founders were concerned with the solution of ethical, scientific, legislative and economic problems. The first Constitution and Bylaws and the first Code of Medical Ethics were adopted, the first legislative committee was appointed, and a resolution outlining the beginnings of interprofessional relations was approved.

The Legislative Committee was instructed to "memorialize the legislature at its next session, praying the enactment of a statute providing for the registration of Births, Deaths and Marriages." The resolution ruled that "members of the Society will discourage the sale of patent or secret nostrums on the part of Druggists and Apothecaries throughout the State, and will patronize insofar as practicable, only those who abstain from the sale of such patent or secret nostrums."

The first full time secretary of the Society was Dr. Harold M. Camp who served for over 35 years until his death in 1959. The first executive administrator, Robert L. Richards, was employed at the time the office was moved to Chicago in 1960 and served until February, 1966. After an interim service by Dr. George F. Lull, Mr. Roger N. White was selected to fill the post in May, 1968. He was succeeded by the present executive administrator, Mr. Alexander R. Lerner, in May, 1981.

The Society published the early transactions in book form, presenting not only the minutes of the House of Delegates, but also all scientific papers given at each annual convention. In 1899 a new era of communications began, for at that time, the *Illinois Medical Journal* was established and became the first "official organ of the Society."

Dr. G. N. Kreider was its first editor and served until 1913, followed by Dr. Clyde D. Pence with Dr. Henry G. Olds as the first managing editor. Dr. Charles G. Whalen became editor in 1919 and he and Dr. Olds served until they died in 1940. Dr. Camp followed Dr. Whalen, and Dr. Theodore R. Van Dellen was the editor for 18 years ending 1977. Subsequently, an Editorial Board was established to review and determine clinical content for the *IMJ*. The Editorial Board reports to the ISMS Publications Committee.

Dr. Whalen spearheaded many important activities in medicine, and has been called "the outstanding champion of the medical profession in its economic contacts." He has been credited as one of the first medical editors to blast "the socialization of medicine in this country." In 1922, he wrote extensively on state medicine, workmen's compensation, compulsory health insurance, free hospitalization and federal aid.

The first Fifty Year Club in the United States was announced by the *Illinois Medical Journal* in 1938.

The fourth largest medical society in the country has developed from these embryonic beginnings. This edition of the *Illinois Medical Journal* offers you an opportunity to contrast the extensive services available to the membership today with those offered in the past.

Principles of Medical Ethics

Preamble: The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

Adopted by the American Medical Association House of Delegates, July, 1980

ILLINOIS STATE MEDICAL SOCIETY

Constitution And Bylaws

Adopted, 1903
As Amended, 1981

CONSTITUTION

ARTICLE I. NAME

The name and title of this organization shall be the Illinois State Medical Society.

ARTICLE II. PURPOSES OF THE SOCIETY

The purposes of this Society are to promote the science and art of medicine, to protect the public health, to elevate the standards of medical education and to unite the medical profession behind these purposes; to promote similar interests in the component societies and to unite with similar organizations in other states and territories of the United States to form the American Medical Association. The Society shall inform the public and the profession concerning the advancements in medical science and the advantages of proper medical care.

ARTICLE III. COMPONENT SOCIETIES

Component societies shall consist of those county medical societies which hold charters from this Society.

ARTICLE IV. COMPOSITION OF THE SOCIETY

The Society shall consist of active members and such other members as the Bylaws may provide.

ARTICLE V. HOUSE OF DELEGATES

Section 1. The House of Delegates shall be the legislative body of the Illinois State Medical Society, and unless otherwise herein provided, its deliberations shall be binding upon the officers, including the Board of Trustees. The House of Delegates shall set the basic policy and philosophy of the Society.
Section 2. The House of Delegates shall elect the general officers, except as otherwise provided in the Bylaws.
Section 3. The House of Delegates shall elect members to serve on the Judicial Panel. The Judicial Panel shall perform all judicial functions on behalf of the Illinois State Medical Society, shall review all questions of ethics and shall interpret all rules and regulations of the Society. Further, it shall conduct all hearings on appeals taken from decisions of component medical societies, arising out of disciplinary actions against physicians.

ARTICLE VI. OFFICERS

The officers of this Society shall be a president, a president-elect, a first vice president, a second vice president, a secretary-treasurer, a speaker and vice speaker of the House of Delegates, and such trustees and other officers as the Bylaws may provide.

ARTICLE VII. BOARD OF TRUSTEES

The Board of Trustees, whose duties are executive, shall have charge of all property and all financial affairs of the Society, and shall perform such other duties as are prescribed by law governing the directors of corporations, or as may be prescribed in the Bylaws.

ARTICLE VIII. CONVENTIONS AND MEETINGS

The Society shall hold an annual convention during which there shall be a business meeting of the House of Delegates which shall be open to all registered members.

ARTICLE IX. THE SEAL

This Society shall have a common seal with power to break, change or renew the same when necessary.

ARTICLE X. AMENDMENTS

The House of Delegates may amend this Constitution at any annual or interim business meeting of the House of Delegates provided that the amendment shall have been proposed at a preceding annual or interim business meeting, and that two-thirds of the members of the House of Delegates seated concur in the amendment.

BYLAWS

CHAPTER I. MEMBERSHIP

Section 1. *Members.* Members shall consist of Regular members, Emeritus members, Retired members, Service members, Distinguished members, In-training members and Student members. Members enjoy full rights and privileges, including the right to vote and hold office and are counted in determining the strength of the Society's Delegation to the American Medical Association.

A. *Regular Members.* Regular members shall be those physicians licensed to practice medicine in all its branches in the State of Illinois, who are either residents of the State of Illinois or who practice principally in Illinois, are persons of good moral character and professional standing and members of their ISMS component society.
Members in good standing moving out of Illinois may retain membership (not to exceed one year) in the Illinois State Medical Society until they are accepted into membership in the medical society of the state to which they have moved.
Physicians serving as full-time employees of the American Medical Association and other physicians licensed in one of the states or territories of the United States but not licensed in Illinois may become regular members although they are not actively engaged in the practice of medicine.

B. *Emeritus Members.* Emeritus members are those who have been regular members in good standing for thirty-five years and have reached or will have reached the age of seventy before the next fiscal year of the Society, have made written application which is received by their component society prior to December 31 and have been recommended by their component society for emeritus status. Such membership shall be effective January first of the year following election. Credit for membership in other American Medical Association constituent societies shall be accorded transferees, provided they have been members of the Society for at least five years.

C. *Retired Members.* Retired members shall consist of those who have been regular members and who by reason of age or incapacity have retired from active practice and who upon application and recommendation from their component society have been made retired members. Retired status is not available to physicians who assume compensated positions after retiring from medical practice.

D. *Service Members.* Physicians serving as medical officers in the United States Governmental Services, who are members of a component society, so long as they are engaged actively fulltime in their respective service, and thereafter if they have been retired on account of age or physical disability, shall be elected to service membership.

E. *Distinguished Members.* Physicians of Illinois or other states or foreign countries who have risen to prominence in the profession, teachers of medicine or of the sciences allied to medicine, not eligible for regular membership, or members of associated arts and sciences, who have made significant contributions to medicine may be nominated by any member of the House of Delegates and may be elected by the House at any annual convention by a two-thirds affirmative vote of those present and voting. They shall not be considered as members in determining the number of delegates to the American Medical Association, but they may participate in all other society activities.

F. *In-Training Members.* In-training members are persons who are medical school graduates, of good moral character and professional standing and serving an internship or residency approved by the American Medical Association in the State of Illinois and are members, of a component medical society. Membership shall end at the end of the year in which training is terminated. Following this, in-training members may apply for regular membership through their component society.

G. *Student Members.* Student members are those who are currently enrolled in an Illinois medical school or are Illinois residents enrolled in an approved medical school within the boundaries of the United States, are of good moral character, professional and academic standing and student members of a component society.

Section 2. *Discrimination of Membership.* Membership in the Illinois State Medical Society shall not be denied or abridged because of color, creed, race, religion, sex or ethnic origin.

Section 3. *Tenure and Termination.*

A. *Tenure of Membership.* The name of a physician on a properly certified roster of members of a component society which has paid its annual assessments, shall be prima facie evidence of membership so long as he complies with the provisions of this Constitution and Bylaws. A member shall hold only one type of membership at any one time.

B. *Termination of Membership.* Any person who is under sentence of suspension or expulsion from a component society shall not be entitled to any of the rights or benefits of the society nor shall he be permitted to take part in any of the proceedings until he has been reinstated. Suspension will in no way affect insurance benefits.

A member whose dues are unpaid by March 31 of the current year ceases to be in good standing and shall be notified of his delinquency by the secretary. A member whose dues or assessments remain unpaid on April 30 of the current year shall automatically be dropped from membership. An individual who has forfeited membership for non-payment of dues or assessments may be reinstated as a member before two years have elapsed, providing, in the interim, he has not been guilty of conduct prejudicial to membership, by the full payment of all dues or assessments in arrears from the date that he was last in good standing. If two or more years have elapsed since he was a member in good standing, he will be required to make application as a new member.

Any member in good standing who resigns voluntarily by December 31 of any year may be reinstated within one year of his resignation by paying all dues and assessments that fell due during the period that his membership lapsed. If more than one year has elapsed since his resignation, he must apply as a new member. Any past member who regains membership by payment of all dues and assessments in arrears shall be eligible for membership benefits only to the extent and in the same manner as a new member initially joining the society.

CHAPTER II. DUES, FUNDS AND ASSESSMENTS

Section 1. *Dues.* Annual dues may be levied by the House of Delegates on each class of membership. The amount of dues shall be recommended by the Board of Trustees and shall be fixed by the House of Delegates at the Annual Meeting and shall include the dues and/or assessments approved by the House of Delegates of the American Medical Association. These shall include the annual subscription to the *Illinois Medical Journal* which shall be at least fifty percent of the regular subscription price of the *Journal.* Only Regular, In-training and Student members shall be assessed annual dues. Dues for its members shall be forwarded by the component society prior to March 31 of each year.

Section 2. *Reduction and Remission of Dues.* Physicians in private practice of medicine may be given a fifty percent reduction in dues during the first year of practice, upon recommendation of their component society. Physicians approved for membership after June 30 shall pay one-half the annual dues for that year. The Board of Trustees may authorize remission of dues of any member on recommendation of his component society for good reason. In such cases the secretary shall recommend remission of dues by the American Medical Association. Emeritus members, Retired members, Service members and Distinguished members are not required to pay dues.

Section 3. *Assessments and Funds.* In addition to dues, assessments may be made on dues-paying members as may be recommended by the Board of Trustees and approved by the House of Delegates. Unless specifically indicated as voluntary, any assessment passed by the ISMS House of Delegates shall be considered a part of a member's dues for the purposes of membership in this organization.

CHAPTER III. EDUCATIONAL AND SCIENTIFIC PROGRAMS

Educational and scientific programs shall be provided by the Society at such times and places as recommended by the Board of Trustees and approved by the House of Delegates.

CHAPTER IV. HOUSE OF DELEGATES

Section 1. *Composition.* The voting membership of the House of Delegates shall consist of 1) delegates elected by component societies, 2) the President, 3) the President-elect, 4) the Vice Presidents, 5) the Secretary-Treasurer, 6) the Speaker and Vice Speaker, 7) Trustees, 8) one delegate elected by the Resident Physicians Section and 9) one delegate elected by the Medical Student Section.

Those having the privilege of the floor without vote are past trustees, past presidents, past speakers, general officers of the American Medical Association, members of the Illinois delegation to the AMA who are not otherwise voting members of the ISMS House of Delegates, and one representative from each member organization of the Council on Affiliate Societies.

Section 2. *Delegates.* Each component society shall be entitled to send one of its members to the House of Delegates each year for each seventy-five members, not to include student members, and one for a major fraction thereof, but each component society which has made its annual report and paid its assessment as provided for in this Constitution and Bylaws shall be entitled to one delegate. The number of delegates to which any component society is entitled shall be determined by the number of members of the component society on

membership rolls of the Illinois State Medical Society as of December 31 of the preceding year. The term of office of a delegate shall begin January first following his election and shall be for two years, or until his successor has been elected. Component societies with only one delegate may elect for one year.

Section 3. *Affiliate Group Delegates.* There shall be a Resident Physicians Section and a Medical Student Section, which shall be open, respectively, to all in-training and medical student members of ISMS. The business of each organization shall be conducted by a governing council in accordance with bylaws approved by the ISMS House of Delegates. The governing council of each organization shall include one delegate with vote in the ISMS House of Delegates and one alternate delegate.

Section 4. *Time and Place of Meetings.* The House of Delegates shall meet twice each year. These two meetings shall be designated as the annual meeting and the interim meeting. The time and place of both shall be as the House determines, except that the interim meeting should not exceed three days and its business shall be restricted in accordance with the provisions of Section 11 of this chapter. The interim meeting should be held in a district other than where the annual meeting is held. Within 100 days after the annual meeting, the Board of Trustees shall decide if there is to be an interim meeting. If the Board finds that there is not sufficient, relevant business for the House, the Board may cancel the interim session.

Section 5. *Quorum.* Fifty delegates representing no less than twenty component societies shall constitute a quorum for the transaction of business.

Section 6. *Special Meetings.* Special meetings of the House of Delegates may be called by a majority of the Board of Trustees or upon petition of twenty component societies. When a special meeting is called, the secretary shall mail a notice to the last known address of each member of the House of Delegates at least ten days before the special meeting is to be held. The notice shall specify the time and place of the meeting and the purpose for which the meeting is called. The meeting shall not consider any business except that for which it was called.

Section 7. *Registration.* Before being seated at any annual or special session, each delegate or his alternate shall deposit with the Reference Committee on Credentials a certificate signed by the President and/or the Secretary of his component society stating that the delegate or alternate has been regularly elected to the House of Delegates. A delegate or his alternate may be seated without credentials, provided he is properly identified and is certified to the secretary of the Illinois State Medical Society. Whenever a delegate or his alternate are unable to attend a particular meeting, the component society may select and certify a substitute delegate who shall have the same powers and duties as did the delegate. A delegate whose credentials have been accepted by the Reference Committee on Credentials and whose name has been placed on the roll of the House, shall remain a delegate until the final adjournment of that session. If a delegate, once seated, is unable to be present for reasons acceptable to the Committee on Credentials, an alternate may be certified by the committee. After the alternate has been seated, he cannot be replaced for that session.

Section 8. *District Division.* The House of Delegates shall divide the state into districts, specifying which counties each district shall include.

Section 9. *Order of Procedure.* The order of business of the House of Delegates shall be determined by the Speaker, subject to approval by the Reference Committee on Rules and Order of Business. Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for all procedure when not in conflict with the Constitution and Bylaws.

Section 10. *Privilege of the Floor.* The House of Delegates by two-thirds vote of those present and voting, may extend an invitation to address the House to any person who in its judgment might assist in its deliberations.

Section 11. *Introduction of Resolutions and Other Business.* All resolutions must be introduced by a voting member of the House. Resolutions submitted nine weeks prior to the annual or interim meeting of the House will be listed in the delegates handbook citing author and subject only; a full copy of all resolutions will be mailed to the delegates. Resolutions to be mailed to the delegates prior to the annual or interim meeting must be received at ISMS headquarters 30 days prior to the annual or interim meeting. Resolutions received after the above date must be approved by the Committee on Rules and Order of Business or by a two-thirds vote of the House of Delegates before they will be considered as business of the House. The only business to be considered by the House of Delegates during an interim meeting will be:

1. Resolutions and information reports introduced by the Board of Trustees as urgent business.
2. Resolutions on matters of national importance and considered urgent introduced by a voting member of the House of Delegates on behalf of the AMA delegation under the same conditions as below.
3. Resolutions introduced by individual delegates, by the Resident Physicians Section, or by the Medical Student Section which are considered urgent and accepted by the Committee on Rules and Order of Business.
4. Decisions of the Committee on Rules and Order of Business regarding the introduction of resolutions at the Interim Meeting may be overruled by a majority of the House of Delegates. Resolutions which are not considered urgent will be carried over to the next annual meeting.

Reports of committees, councils and officers should be informational and should not contain requests for House action. Recommendations of committees, councils and officers should be submitted to the House in resolution form. Reports, resolutions and requests for action after the opening of the first session of the House of Delegates shall require for consideration a two-thirds affirmative vote.

Section 12. *Judicial Panel.* The House of Delegates shall create a Judicial Panel and shall elect five (5) of its active members to serve on the Panel, in a manner set forth in Chapter XI of these Bylaws. The Judicial Panel shall review all questions of ethics and shall interpret the laws and rules of the Society. It shall consider all questions of an ethical nature and it shall conduct hearings on appeals taken from decisions of component societies on ethical relations matters and other disputes involving the rights and privileges of physicians.

CHAPTER V. ELECTION OF OFFICERS

Section 1. *Officers.* The officers of this Society shall consist of the president, president-elect, first and second vice presidents, secretary-treasurer, speaker and vice speaker, twenty-one trustees and one trustee-at-large, and delegates and alternate delegates to the American Medical Association.

Section 2. *Elections.* All elections shall be by ballot except when there is only one candidate for a given office, then election may be by voice vote.

The majority of votes cast shall be necessary to elect.

The election of officers, delegates and alternate delegates to the AMA, shall follow the completion of action on current and old business at the final session of the House of Delegates.

Section 3. *Terms of Office.* The president-elect, vice-presidents, secretary-treasurer, the speaker and vice speaker shall be elected annually by the House of Delegates to serve for a term of one year.

Members of the Board of Trustees shall be elected by the House of Delegates to serve for a term of three years. The number of consecutive terms that may be served by a trustee is limited to three. This shall become effective July 1, 1975, and shall not have retroactive application.

The speaker and vice speaker shall not be elected for more than two consecutive terms to their respective offices; they shall be elected from the membership of the House of Delegates.

Delegates and alternate delegates to the AMA shall be elected by the House of Delegates for two-year terms, except in the event of their election to fill a portion of another's unexpired term.

The president-elect shall be inducted into the office of president by the retiring president during the final session of the House of Delegates. After assuming office at the adjournment of the annual business meeting, he shall continue in office until his successor has been elected and installed. Following his retirement as president, he shall automatically become trustee-at-large for a term of one year.

CHAPTER VI. DUTIES OF OFFICERS

Section 1. *The President.* The president of the Illinois State Medical Society shall lead the Society in all its functions. He shall deliver an annual address at such time as may be arranged, and perform other duties as custom and parliamentary usage may require. He shall also appoint such task forces as may be needed by the Society.

Section 2. *The President-Elect.* The President-Elect shall attend all meetings of the Board of Trustees and the Executive Committee, shall study the relationship between the Chairman of the Board and the President and shall study the responsibilities and duties of the Executive Administrator, Chairman of the Board and President so that when his term as President commences, he will have an understanding of his duties and responsibilities. He shall also serve as chairman of the Committee on Planning and Priorities.

Section 3. *The Vice Presidents.* The vice presidents shall act for and perform such duties for the president as he shall direct. They shall, when so acting, implement and advance the programs and policies of the president.

In the event of the president's death, resignation or removal from office, the first vice president shall succeed to the presidency.

In the event of a vacancy in the office of first vice president, the second vice president will become first vice president.

Section 4. *Successor to President-Elect.* In the case of death, resignation, or removal from office of the president-elect, the office shall be filled by the House of Delegates at the next annual convention by election at a time recommended by the Reference Committee on Rules and Order of Business.

Section 5. *The Speaker.* The Speaker, who shall be versed in parliamentary procedure, shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He shall appoint all committees of the House of Delegates.

He shall seek the advice of officers and trustees.

He shall be a member of the Committee on Constitution and Bylaws.

Section 6. *The Vice Speaker.* The vice speaker shall preside for the speaker in the latter's absence at his request. In case of death, or resignation of the speaker, the vice-speaker shall serve during the unexpired term.

Section 7. *The Secretary-Treasurer.* In addition to the rights and duties ordinarily devolving on the secretary of a corporation by law, custom or parliamentary usage, and those granted or imposed in other provisions of the Constitution and these Bylaws, the secretary-treasurer shall be the official custodian of all securities and the income therefrom owned by the Society, subject to the direction and disposition of the Board of Trustees. He shall be a member of the Finance Committee of the Board of Trustees.

The Board of Trustees may select a bank or trust company to act as custodian in the place of the secretary-treasurer, of all or any part of such securities and to act as agent of the Society in collecting the income therefrom.

He shall perform such other duties as may be directed by the House of Delegates or by the Board of Trustees.

In the event of a vacancy in the office of the secretary-treasurer, the Board of Trustees shall fill the vacancy until the next annual election.

Section 8. *Delegates and Alternate Delegates to the American Medical Association.* Members of the Illinois State Medical Society's delegation to the American Medical Association are officers of this society and, as such, share jointly with the Board of Trustees the responsibility for carrying out policies established by the ISMS House of Delegates as they pertain to the AMA activities.

They shall have the privilege of the floor in the ISMS House of Delegates.

Members of the delegation are responsible for participating actively in the House of Delegates of ISMS and the AMA to the extent allowed under the bylaws of each organization. They are responsible for submitting to the AMA appropriate resolutions and they are obliged to seek passage of these resolutions in the AMA House of Delegates until such time as circumstances and/or additional facts make continued effort impractical or impossible.

CHAPTER VII. THE BOARD OF TRUSTEES

Section 1. *Composition.* The Board of Trustees shall consist of: twenty-one trustees elected by the House of Delegates, one trustee-at-large (the retiring president, who shall serve a term of one year), the president, the president-elect, the speaker and vice speaker of the House of Delegates, the first vice president and second vice president, and the secretary-treasurer. Ten trustees shall be chosen from District 3 and one from each of the other eleven districts.

The trustee districts of the Illinois State Medical Society shall be:

First District—Counties of Kane, Lake, McHenry.

Second District—Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford.

Third District—Cook County.

Fourth District—Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren.

Fifth District—Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon.

Sixth District—Counties of Adams, Brown, Calhoun, Cass, Greene, Jersey, Macoupin, Madison, Morgan, Pike, Scott.

Seventh District—Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby.

Eighth District—Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion.

Ninth District—Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson.

Tenth District—Counties of Monroe, Perry, Randolph, St. Clair, Washington.

Eleventh District—Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will.

Twelfth District—Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago.

Section 2. *Duties.* The duties of the Board of Trustees are executive and custodial.

A. *Executive Duties.* The Board of Trustees shall implement all mandates from the House of Delegates except in matters of property or finance when it shall have sole authority.

The Board of Trustees may establish a not-for-profit corporation of physicians known as the Illinois Foundation for Medical Care.

The Board of Trustees may request a report from any committee in the interim between meetings of the House of Delegates.

B. *Custodial Duties.* The Board of Trustees shall have charge and control of all property of whatsoever nature belonging to the Society, and of all funds from whatsoever source belonging to the Society.

No person shall expend or use for any purpose money belonging to the Society without the approval of the Board of Trustees.

All money received by the Board of Trustees and its agents, resulting from the duties assigned them, shall be paid into the treasury of the Society, and all orders on the treasury for disbursement of money shall be approved by the Board.

The Board of Trustees shall formulate rules governing the expenditure of money to meet the necessary running expenses and fixed charges of the Society.

All acts of the House of Delegates involving the expenditure, appropriation or use in any manner of money, or the acquisition or disposal in any manner of property of any kind belonging to the Society, must be approved by the Board of Trustees before same shall become effective.

Funds may be appropriated to encourage scientific investigation, medical education or any other purpose deemed proper and approved by the Board of Trustees.

Section 3. *Executive Administrator.* The Board of Trustees shall employ an executive administrator (who, when he shall be a physician, may be designated as the executive vice president) whose duties shall be determined by the Board. He shall be responsible to the chairman of the Board. The Board shall review at each of its meetings the interim activities of the administrator. The Board also shall employ such other people as are needed for the conduct of the affairs of the Society.

Section 4. *Meetings.* The Board of Trustees shall meet daily during the annual convention of the Society, and at such other times as necessity may require, subject to the call of the chairman, or on the petition of the majority of the Trustees.

Section 5. *Organization.*

A. *Chairman.* The Board of Trustees shall meet on the last day of the annual convention and elect from among its members a chairman. He shall hold office for one year and may succeed himself for one additional year. The immediate past president shall temporarily assume the responsibilities of the Chairman of the Board in the latter's absence.

B. *Duties of the Chairman.* The chairman of the Board of Trustees shall prepare an agenda and shall preside at all meetings of the Board. He shall make an annual report to the House of Delegates. He shall be chairman of the Executive Committee. He shall present the report of the actions of the Executive Committee to the Board. He supervises the work of the Executive Administrator, appoints members of councils and committees with approval of the Board, and monitors execution of Board decisions and resolutions. He may delegate any of his duties.

Section 6. *Quorum.* Eleven members of the Board of Trustees from at least seven districts shall constitute a quorum for the transaction of business.

Section 7. *County Societies.* The Board of Trustees shall have authority to organize the physicians of two or more counties into societies to be suitably designated, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

Section 8. *Publication.* The Board of Trustees shall provide and superintend the publication and distribution of all proceedings, transactions and memoirs of the Society, and shall have authority to appoint an editor and such assistants as it deems necessary.

Section 9. *Bonding.* The Board of Trustees shall provide at the expense of the Society, adequate bond for those officers and employees of the Society it considers require bonding.

Section 10. *Duties of Trustees.* Each trustee shall be the organizer, consultant, advisor, administrator and speaker for the members of his district, and represent the Society as well as the members of his district at the Board meetings.

Each trustee should visit the societies in his district at least once a year. He shall make an annual report of his work and the condition of the profession in each society in his district to the Board of Trustees and to the House of Delegates.

Where his district is composed of more than one county, the trustee shall be an ex-officio member of all district committees. He shall report to the Board of Trustees the actions of the component societies in reports of these committees.

The necessary traveling expenses incurred by such trustee in the line of the duties herein imposed, may be allowed by the Board of Trustees upon presentation of a properly itemized statement.

Section 11. *Vacancies.* If during the interval between two annual conventions, sickness, death, or removal from the state or district, or any other reason prevents a trustee from attending the duties of his district, or if he shall be absent from two consecutive meetings of the Board, his office may be declared vacant at the discretion of the Board. The Board shall have the authority to fill the vacancy for the period between the date at which the office was declared vacant and the next annual meeting of the House of Delegates.

Section 12. *The Benevolence Fund.* Each year the Board shall appropriate from the funds of this Society such sum or sums as it may deem proper to be held in a fund to be known as "The Benevolence Fund." This fund is established and shall be used only for the assistance or relief of needy members of this Society, their widows, widowers, or minor children. The assets shall be held in the treasury of this Society in a separate fund. Donations or bequests to the Benevolence Fund automatically become a part of these assets.

Section 13. *Audit and Financial Statement.* The Board of Trustees shall employ annually a certified public accountant to audit all accounts of the Society, and present a statement of same in its annual report to the House of Delegates.

This report also shall specify the character and cost of all publications of the Society during the year, and the amount of all other property belonging to the Society under its control, with such suggestions as it may deem necessary.

CHAPTER VIII. DISTRICT COMMITTEES

Each trustee district which is composed of more than one county, shall have an Ethical Relations Committee, a Peer Review Committee, and such other committees as required to provide to each component society those services the component society may not be able to provide for itself. District committees shall function only at the request of a component society within the district; except that district committees may be assigned to act when the Ethical Relations or Peer Review Committees of the component society fail to act as set forth in Chapters XI and XII of these bylaws.

Complaints initially received by district committees shall be referred immediately to the component society for action.

District committees shall be governed by the procedural rules and regulations governing the counterpart state society committee or by these Bylaws.

Reports of findings and recommendations of these district committees shall be made to the component society which requested action.

The district trustee shall include a summary of the activities of each of these committees and the findings in general, in his annual report to the House of Delegates.

The committee members shall be elected at a meeting of the delegates of the district called by the trustee of the district, before or during the annual convention of the Illinois State Medical Society. Chairmen of the committees shall be designated by the trustee of the district, and the trustee shall be an ex-officio member of each committee.

CHAPTER IX. COMMITTEES

Section 1. *Committee Structure.* The committee structure of the Illinois State Medical Society shall be as follows:

A. Councils (standing committees)
B. Committees Reporting Directly to the Board of Trustees
C. House of Delegates Committees
D. Board of Trustees Committees

Section 2. *Councils.*

A. The Medical-Legal Council shall be concerned in the areas of:
 1. Liaison with the Illinois Bar Association
 2. Liaison with courts, particularly where impartial medical testimony is involved.
 3. Implementation of the Impartial Medical Testimony Rule
 4. Legal aspects of medical practice other than in the area of mental health
 5. Licensing and standards of practice
 6. Quackery
 7. Anatomical gifts and organ transplants

B. The Council on Governmental Affairs shall be concerned in the areas of:
 1. Federal and state legislation—analysis and communication
 2. Legislative liaison—both state and federal
 3. Political education

C. The Council on Education and Manpower shall be concerned in the areas of:
 1. Liaison with medical schools, curricula, etc.
 2. Health manpower and training
 3. Internships, residencies, etc.
 4. Scientific assembly
 5. Student loans
 6. Liaison with American Medical Student Association
 7. Continuing medical education

D. The Council on Economics shall be concerned in the areas of:
 1. Ongoing relationships with third parties
 2. Health care cost and utilization

E. The Council on Medical Service shall be concerned with:
 1. The provision of medical care and health services in the public and private sectors
 2. Emergency medical services
 3. Health care of the poor, aged and those in rural areas
 4. Maternal and child health
 5. Nutrition
 6. Workmen's compensation
 7. Environmental and community health
 8. Rehabilitation
 9. Health care facilities and delivery systems

F. The Council on Public Relations and Membership Services shall be concerned in the areas of:
 1. Publicity and promotion
 2. News media relations
 3. Exhibits and public service programming
 4. Religion and medicine
 5. New member orientation and membership benefit explanation

G. The Council on Mental Health and Addiction shall be concerned in the areas of:
 1. Facilities and services
 2. Liaison with Department of Mental Health
 3. Legal aspects of commitment, etc.
 4. Narcotics and dangerous drugs
 5. Alcoholism

H. The Council on Affiliate Societies shall be concerned in the areas of:
 1. Liaison between the affiliate society and ISMS
 2. Scientific resource information and advice to ISMS
 3. Consultation to other councils, e.g., postgraduate education, health care delivery, publicity, legislation
 4. Advances of medical science in special fields
 5. Recommendations to the Board of Trustees on legislative matters affecting any specialty society

Section 3. *Organization of Councils.*

A. Councils and the chairmen thereof shall be appointed by the Board of Trustees.

B. Each Council shall have authority to request the Board of Trustees to appoint subcommittees under the councils for any purpose within the functions of the Council. A member of the Council shall be designated as chairman of each subcommittee and shall be selected by the Board of Trustees. Each subcommittee shall be used only for the specific purpose or purposes assigned to it and shall terminate as soon as its final report has been made or at the direction of the Board. The chairman of a Council may not serve as chairman of any subcommittee of the Council.

C. Members of the Illinois State Medical Society (who are not members of the Board of Trustees) may be appointed to serve as chairmen or members of any council or committee. Students nominated by the Governing Council of the ISMS Medical Student Section and resident physicians members nominated by the Governing Council of the ISMS Resident Physicians Selection may be appointed by the Board of Trustees as members of any appropriate council or committee. Such members shall be permitted full privileges of committee membership, including the right to vote. Members of the Board of Trustees may serve as advisory members to any council or committee.

 Recommendations for membership on any committee may be submitted to the Board of Trustees by the House of Delegates, or in writing by any member of the Society.

 A state committee which reviews the decisions of a similar committee of a component society may not have as a member one who currently serves on the same committee of a component society or district.

D. Each Council shall submit for adoption a budget for the ensuing year which shall include any subcommittees, and the Board of Trustees shall determine the appropriation for each Council. Requests for additional funds must be approved by the Board before they are committed.

E. The president of the Society, the speaker of the House and the chairman of the Board shall be ex-officio members without vote of the various Councils and task forces, and may attend all committee meetings.

F. Terms of office of members of the councils shall be one year, but may be terminated at any time at the discretion of the Board. No member of a council shall serve more than five consecutive one-year terms.

G. Vacancies on any council or subcommittee thereof may be filled or membership therein may be enlarged or decreased by the Board of Trustees. The areas of concern of councils may also be enlarged or decreased by the Board of Trustees.

H. The chairman of a council or subcommittee thereof, when he considers it expedient and with the consent of two-thirds of the members of the council, may conduct business or hold meetings by mail or by conference call, provided all members of the council are given opportunity to participate, that minutes of the transactions are recorded, approved by members participating, and circulated among all members.

I. Reports of subcommittees shall be made by the chairman to the council under which they are operating.

 Reports of council activities shall include recommendations on reports and requests from subcommittees, and shall be made to the Board of Trustees by the chairman of the council.

The chairman of any subcommittee may request the Board of Trustees to allow him, or any member of his subcommittee, to appear before the Board and to be heard.

All councils shall submit to the House of Delegates written reports summarizing all actions. Requests for House action or recommendations affecting medical society policy must be submitted to the House in resolution form.

J. *Affiliate Societies*
 1. *Qualifications.* Affiliate societies shall be those recognized societies of Illinois
 a) as may be approved by the Board of Trustees
 b) which desire representation on the Council on Affiliate Societies
 2. *Representation.* Each affiliate society shall be entitled to one member on the council. This representative shall be a member of ISMS.

Section 4. *Task Forces.*

A task force, an ad hoc body to address a specific complex issue and report by a date certain to the Board of Trustees, shall be appointed by the President upon direction of the House of Delegates or request of the Board of Trustees. It shall consist of persons from any two or more of the following categories: council members, committee members, other members of the Society, non-members of the Society. It shall be dismissed upon making its final report.

Section 5. *Committees Reporting Directly to the Board of Trustees*

A. Planning and Priorities Committee. This committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties, it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President. The President-Elect shall serve as chairman of the committee.

B. Committee on Insurance. This committee will review society-sponsored insurance programs, study these plans, make suggestions for changes, additions and cancellation of policies, and will investigate other insurance programs that may benefit society members.

C. Committee on Health Planning. The committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The committee shall maintain ongoing liaison with the State Health Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies.

D. Committee on Drugs and Therapeutics. The Committee shall meet periodically to refine the drug list contained in the Drug Manual. It shall work with the Illinois Department of Public Aid in an effort to keep the Drug Manual current and effective. When suggestions and comments from members are submitted to the committee, it shall review them and present them to the Department of Public Aid when necessary. The committee shall also consider other drug matters affecting the policy of the medical society.

E. Health Data Committee. The Committee shall maintain ongoing awareness of (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes, health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of PSROs, HSAs, the Illinois Cooperative Health Data System (ICHDS), governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees, and other appropriate persons within ISMS advised on the data collection matters.

F. Peer Review Appeals Committee. This committee shall serve as an appellate body for state peer review by considering cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee will serve as liaison to local peer review committees and monitors activities around the state.

G. Committee on CME Accreditation. It shall be the responsibility of this committee to adopt necessary procedural rules and to prescribe forms to be used in the conduct of CME accreditation. The committee shall review sponsor applications and survey team reports for intrastate CME sponsors, and make decisions on grant of initial accreditation and continuation of accredited status.

Section 6. *House of Delegates Committees.* House of Delegates Committees of the Illinois State Medical Society shall be as follows:

A. Committee on Credentials shall consider all questions regarding the registration and credentials of the delegates. It shall distribute and receive the attendance slips for each session of the House of Delegates and perform any other duties assigned to it.

B. Committee on Rules and Order of Business shall consist of five members nominated by the Speaker and confirmed by the House immediately prior to the conclusion of business at its annual meeting. The committee will serve until the next annual meeting.

It shall consider all matters regarding rules governing action, method of procedure and order of business for the House of Delegates. It shall also consider late resolutions for introduction at the annual meeting and resolutions introduced by individual delegates at the interim meeting.

C. Committee on Tellers and Sergeants-at-Arms shall:
 1. Serve the speaker of the House of Delegates.
 2. Distribute, collect and tally votes when a ballot is taken or a numerical tally is required.
 3. Certify those in attendance in closed or executive sessions of the House of Delegates.

D. Committee on Changes in the Constitution and Bylaws shall consider all proposed amendments to the Constitution and Bylaws. The chairman of the Trustees Committee on Constitution and Bylaws, or his representative, shall serve in an advisory capacity to this reference committee and shall attend all sessions, including the executive sessions of the refrerence committee, to assist in the preparation of the report of the committee to the House of Delegates.

E. Ad hoc committees may be appointed by the speaker of the House of Delegates as the needs arise and any member of the Illinois State Medical Society may serve upon such committee. The number appointed to such committees shall be at the discretion of the speaker and the term of the committee shall be for such duration as is necessary to complete the task assigned but shall not exceed a duration of one year. Between meetings of the House of Delegates ad hoc committees shall report to the Board of Trustees, keeping it informed of all current activities.

F. Such other reference committees as the speaker shall deem necessary to conduct the business of the House, or consider the reports of officers, trustees, executive administrator, the reports of committees pertaining to administrative activities, economic activities, scientific activities, public relations activities and legislative activities, as well as such resolutions, reports, and proposals as shall be brought before the House of Delegates.

Section 7. *Organization of House of Delegates Committees.*

A. Immediately after the organization of the House of Delegates at each annual or special meeting, the speaker shall

announce the appointment, from among the members of the House, of such committees as may be deemed expedient by the House of Delegates.

Each committee shall consist of five or more members unless otherwise provided, the chairman to be announced by the speaker. These committees shall serve during the meeting at which they are appointed.

B. References, resolutions, measures and propositions presented to the House of Delegates shall be referred to the appropriate committee, which shall report to the House of Delegates before final action shall be taken. A two-thirds affirmative vote of the House of Delegates shall be required to suspend this rule.

C. Each reference committee shall, as soon as possible after the adjournment of each session, or during the session if necessary, take up and consider such business as may have been referred to it, and shall report on same at the next session, or when called upon to do so.

Section 8. *Board of Trustees Committees.* The Board of Trustees shall form the following committees within itself:

A. The Executive Committee shall consist of the president, president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer, the trustee-at-large, and the immediate past chairman of the Board, provided he is still a trustee. If the immediate past-chairman of the Board is no longer a trustee, the chairman of the Policy Committee shall be a member of the Executive Committee. The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

The Board of Trustees may delegate to the Executive Committee any authority which it possesses and may authorize it to act in any given situation. In all matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Medical Benevolence Committee and Policy Committee and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

B. The Finance and Medical Benevolence Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop for approval of the Board through the Executive Committee, a budget for the fiscal year. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

This committee shall also:

1. Examine applications to the Society for assistance under the Medical Benevolence program to determine eligibility for assistance;
2. Keep the names of the beneficiaries confidential and known only to the committee;
3. Recommend the allotment for each recipient; and
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

C. The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall continually review past and current proceedings of the House of Delegates to determine the established policies of the Illinois State Medical Society. It shall make recommendations for future policy by Board resolution to the House of Delegates.

D. The Committee on Constitution and Bylaws shall consist of five members—the Speaker of the House and four members appointed by the Chairman of the Board. It shall:

1. Receive from individual members, county societies, committees, the Board of Trustees, and the House of Delegates, all suggestions and proposals for modification of the Constitution and Bylaws.
2. Prepare for the consideration of the House of Delegates, all changes in the Constitution and Bylaws.
3. Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

E. The Committee on Publications shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal.*

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editor in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates, standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish format, cover, type faces and general layout of the *Journal.*

It shall review, edit and supervise the publication of other materials as directed by the Board of Trustees.

F. The Advisory Committtee to the Auxiliary shall consist of the immediate past president as chairman, the president and the chairman of the Board of Trustees.

The committee shall provide advice and assistance to the president of the Auxiliary in her program for the year, and shall assist her in interpreting the activities of the Illinois State Medical Society.

G. The Committee on Third Party Payment Processes shall consist of members of the Board of Trustees and be activated whenever an issue or problem requires high level negotiations between ISMS and third-party payors.

H. The Board of Trustees may from time to time appoint such ad hoc committees as it may deem necessary but the duration of such committees shall be temporary and they shall function only for the specific purpose assigned and shall be terminated as soon as final reports have been made or at the direction of the Board.

Section 9. *Powers of the Board of Trustees.* The Board of Trustees shall have power to increase or decrease the number of its committees, to change the area of concern of such committees, to enlarge or decrease membership and to fill vacancies thereon.

Section 10. *Term of Membership.* The term of the members of the Board of Trustees Committees shall be for a duration of one year and they shall be selected by the Board annually immediately after the election of officers.

CHAPTER X. COUNTY SOCIETIES

Section 1. All county societies now in affiliation with this Society, or those which may hereafter be organized in this state, which have adopted principles of organization in harmony with this Constitution and Bylaws, shall upon application to and approval by the Board of Trustees, receive a charter from and thereby become a component part of this Society, and members thereof shall become members of this Society and the American Medical Association.

Section 2. Charters shall be issued only on approval of the Board, and shall be signed by the president and the secretary of this Society.

The Board shall have authority to revoke the charter of

any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

Section 3. Only one component medical society shall be chartered in any county.

Section 4. Every registered physician holding the title of Doctor of Medicine or its equivalent, who either (1) resides in the jurisdiction of a component society, or (2) resides in a state other than Illinois but practices principally in the jurisdiction of a component society and who is of good moral character and professional standing, shall be eligible to membership in that component society.

The component county society shall be the sole judge of the qualifications of its members, subject only to the stipulations contained in the Constitution and Bylaws.

Section 5. Any physician who has been disciplined by any action of a component society and believes he has not had a fair trial, shall have the right of appeal to the Judicial Panel.

Section 6. When a member in good standing in a component society changes his residence to another county in this state, such change of residence shall terminate his membership in such component society. (This ruling shall not apply to members in military service or in the service of the State or the United States government.)

Such member shall be entitled, upon his request, to a statement from his former secretary as to his standing. This statement of standing shall be issued without cost to the applicant.

He shall present this statement to the component society of the county to which he removes and it shall accompany his application for membership. The board of censors of the society receiving his application shall give this statement of prior standing due consideration before accepting or rejecting his application for membership.

Section 7. A physician living on or near a county line, or practicing partly or totally in an adjacent county, may hold his membership in the county most convenient for him, provided he submits written authorization to that society from the component society in whose jurisdiction he resides.

Section 8. The secretary of each component society shall keep a roster of its members, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such a roster the secretary shall note any changes in the personnel of the profession by death or by removal to or from the county. When requested, he shall furnish on blanks supplied him for the purpose, an official report containing such information for the secretary of this Society and likewise for the trustee of the district in which his county is situated.

Section 9. The secretary of each component society shall forward an annual report consisting of a roster of members as of December 31 of the preceding year and a list of current officers, delegates and alternate delegates to the secretary of this society no later than 90 days prior to the annual meeting.

Section 10. Any component society which fails to transmit the dues collected from its members prior to March 31 shall be held as suspended and none of its members shall be permitted to participate in any of the business or proceedings of the Society or of the House of Delegates until such requirements have been met.

Section 11. Members of the Illinois State Medical Society shall be bound by the Constitution and Bylaws of ISMS.

CHAPTER XI. ETHICAL RELATIONS

PART 1. COMPONENT MEDICAL SOCIETY

Each component society may have, either by appointment or election, an Ethical Relations Committee whose duty it shall be to conduct disciplinary hearings under this chapter. Although the component society may develop its own procedures for conducting such hearings, each society will, to the extent possible, comply with the general guidelines set forth by the Judicial Panel, which panel is created under this chapter; such guidelines referred to as the *Handbook for the Conduct of Disciplinary Proceedings.*

PART 2. DISTRICT ETHICAL RELATIONS COMMITTEE

The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Ethical Relations Committee. The component society may elect to request that the District Ethical Relations Committee, serving its area, function in its behalf and shall conduct such disciplinary proceedings as are required. In the event that a component society's Ethical Relations Committee does not make a reasonable effort to hold a hearing on a properly filed complaint, within a reasonable time period, either the complaining party or the physician against whom formal written charges have been brought, may petition the Illinois State Medical Society Judicial Panel to request the District Ethical Relation Committee to intervene and take jurisdiction of the matter. In the event of a dispute resulting from such actions, the Judicial Panel shall determine, as provided in Part 7 of this chapter, the appropriate forum for the hearing.

PART 3. OFFENSES

A. Disciplinary action may be taken against any member of a component society when:
 1. The physician has been convicted, adjudged or otherwise recorded as guilty by any court of competent jurisdiction of a felony or a crime involving moral turpitude; or
 2. He has been adjudged or otherwise recorded as guilty by his component society of:
 a. acts of serious misconduct as a physician; or
 b. a violation of the Constitution or Bylaws of his component society, or of the Principles of Medical Ethics promulgated by the American Medical Association; or
 3. He has been judged guilty of a violation of a law or regulation by an administrative agency of government resulting in the termination of his privileges, license, or other rights held by the physician.

PART 4. STANDARDS AND PROCEDURES

A. The committee, in its deliberations, shall evaluate acts by the standards established in the Constitution and Bylaws of the Illinois State Medical Society and/or the component medical society of which the accused is a member.

B. Disciplinary action may be initiated by the component society or the Illinois State Medical Society upon receipt of formal written charges filed by a licensed physician practicing or residing in the State of Illinois alledging violations of any of the offenses enumerated in this Part 3. Written charges received by the Illinois State Medical Society shall be referred to the secretary of the component society in which the accused physician maintains membership or practices medicine. The component society may then exercise the choice of proceeding through its own Ethical Relations Committee or referring the complaint to the District Ethical Relations Committee. Disciplinary action may also be initiated upon the filing of a complaint of an alleged violation of any of the listed offenses by a component medical society against a physician, such complaint having been filed by the secretary of the component society, on its behalf.

PART 5. PENALTIES

The component society's or District Ethical Relations Committee shall submit their recommendations for disciplinary action in writing to the component society. The recommendation shall be to: (a) acquit; (b) censure; (c) suspend; or (d) expel from membership. A decision based on a recommendation to acquit shall be final and not appealable.

The recommendation to censure shall mean an entry will be made in the accused physician's membership file to the effect that the physician has been found guilty of the act complained of and that he has been properly advised of the finding. No deprivation of membership privileges will be imposed.

The recommendation to suspend shall mean that for a fixed period of time, to be determined by the component society, the accused physician shall forfeit his rights to vote and otherwise to participate in the affairs of the local, state and national societies. In all other respects, his membership shall remain intact.

The recommendation to expel shall mean that the membership status and all privileges and rights attendant thereto of the accused physician shall be terminated for a period of one year. At the conclusion of the twelve (12) months period, the physician may re-apply for membership in the society; however, he shall then have the burden of demonstrating that the conditions and factors which contributed to his expulsion have since been removed and need not be considered in the process of reviewing his application for renewed membership.

PART 6. DECISION BY COMPONENT MEDICAL SOCIETY

A. The recommendations of the Ethical Relations Committee must be presented to the component society for approval, rejection, modification or reconsideration. The complainant and accused shall be given reasonable advance notice of the date set for the meeting when the committee's recommendations will be considered. The complainant and the accused each may submit a written statement of their respective positions to the component society. If either the complainant or the accused feels that errors were made during the proceeding before the Ethical Relations Committee or that new and additional relevant information has become available since the committee conducted its hearing, said party shall submit a description if these errors or new evidence to the component society prior to the component society's review. At the discretion of the component society, the complainant, the accused, and their legal counsel may appear before the society to testify.

B. If the component society believes that the new evidence not previously disclosed to the committee is relevant and material or that procedural error was committed, that component society may refer the matter back to the Ethical Relations Committee for reconsideration. The notice shall state the reasons for the referral and shall set a time limit within which a subsequent hearing must be conducted and recommendations must be presented to the component society.

PART 7. JUDICIAL PANEL

A Judicial Panel shall be created and empowered to conduct all appellate hearings arising out of Chapter XI of these bylaws and such other appellate proceedings as many derive from disputes or grievances among physicians practicing or residing in the State of Illinois. The panel shall render its decisions based on these hearings and related deliberations. The panel may, on request, adjudicate disputes among individual physicians or physician groups, between component medical societies and district Ethical Relations Committees, and between local medical societies and the Illinois State Medical Society when such disputes involve or impact the individual rights of physicians practicing or residing in this state; except that the Judicial Panel shall have the power on its own initiative to intervene when an Ethical Relations Committee of a component medical society fails to act in a timely manner, as provided in Part 2 of this chapter. The component medical societies and District Ethical Relations Committees shall cooperate with the Judicial Panel in the collection of statistical information for the purpose of identifying the manner in which due process of law is guaranteed to physicians accused of violations of provisions of these bylaws.

The decisions of the Judicial Panel shall be final; except that an appeal may be requested by the accused member under the Constitution and Bylaws of the American Medical Association. The Judicial Panel of the Illinois State Medical Society shall confine all decisions to its proper appellate function which is to sustain, remand or overturn a decision rendered or reduce a penalty imposed by a county society or district ethical relations committee.

Members of the Judicial Panel shall be elected by a majority of the members of the House of Delegates, upon nomination by the President of the Illinois State Medical Society. The panel shall consist of five active members of the Illinois State Medical Society, elected for five-year terms on a staggered basis; except, that of the members elected to fill the initial terms on the panel, one shall be elected for an initial one-year term, one shall be elected to an initial two-year term, one shall be elected to an initial three-year term, one shall be elected for an initial four-year term and one shall be elected to an initial five-year term. Those elected to serve as members of the initial panel may be re-elected to a second full five-year term; however, succeeding members of the panel may only serve one five-year term. Those members of the Judicial Panel elected at the interim meeting in November, 1978, would serve until the next appropriate meeting of the House of Delegates.

In the event a vacancy on the Judicial Panel occurs, the President of the Illinois State Medical Society shall nominate a successor who shall serve, if approved by the Board of Trustees, until the next meeting of the House of Delegates. At its meeting following such interim appointment, the House of Delegates shall elect a member of ISMS to fill the unexpired term on the Judicial Panel by the procedure described in these bylaws.

In the event members of the Judicial Panel are unable to participate in an Appellate hearing for any reason, resulting in fewer than three members of the Panel ready and able to participate in a given appeal, the President shall recommend to the Executive Committee of the Board of Trustees and that committee shall appoint additional interim members to fill out the five-member Panel. These interim members shall serve only for the purpose of conducting and participating in the pending Appeal and their term as members of the Panel shall begin and end with the conduct of the Hearing assigned to them by the Executive Committee of the Board of Trustees.

The members of the panel shall elect from among them a chairman who shall serve until his successor shall be elected by a majority of the members of the panel.

The panel shall meet as often as is necessary in order to assure a reasonably prompt disposition of matters properly placed before it and shall convene on the call of the chairman. Three members of the panel shall constitute a quorum for the transaction of its business.

The panel shall adopt such rules as it deems appropriate for the orderly conduct of its duties. A written copy of such rules shall be made available to each component society and to the chairman of the Board of Trustees. The panel shall publish a *Handbook for the Conduct of Disciplinary Proceedings,* to be approved by the House of Delegates and which shall serve as a general guideline to all component medical societies in the conduct of hearings.

The chairman of the panel shall report to the House of Delegates at each of its annual meetings, thereby informing the members of the House of Delegates of the proceedings and deliberations of the panel during the preceding twelve months.

PART 8. DUE PROCESS SAFEGUARDS

In all proceedings conducted in accordance with the provisions of this chapter, the accused physician's rights to due process of law shall be honored and observed. The *Handbook for the Conduct of Disciplinary Proceedings* will set forth general guidelines for affording such due process protections.

CHAPTER XII PEER REVIEW
PART 1—DEFINITIONS

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical Society peer review shall be conducted at the local level whenever possible. Ethical relations issues identified during deliberations of the Peer Review Committee shall be appropriately referred. Peer Review Committees should apply standards developed by appropriate physician organizations; such standards to be tempered by customs and practice followed in the local community in which the evaluation is undertaken. Decisions and recommendations of Peer Review Committees shall be advisory only.

PART 2—COMPONENT SOCIETY PROCEDURES

A. *Responsibilities*—Each component Society may have, either by appointment or election, a review committee whose duties it shall be to review all proper complaints and inquiries brought before it by physicians, patients and, at local option, other parties. In the event a component Society shall choose not to appoint or elect its own review committee, the component Society may, by action of a majority of its members eligible to vote, delegate the peer review functions to an appropriate physician organization competent to perform these functions within the geographic area served by the component Society or to a District Peer Review Committee as provided for hereinafter. The District Peer Review Committee shall function and operate on behalf of any component Society which does not establish such a committee.

B. *Procedures*—The review committee of the component Society shall establish reasonable rules of procedure but shall not be bound by technical rules applied in courts of law or in administrative hearings conducted by governmental agencies. All complaints and inquiries shall be reduced to writing and shall be signed by the individual making the complaint or inquiry. Complaints received by the Illinois State Medical Society shall be referred to the proper component Society or District Committee.

C. *Timely Reviews*—The review committee of the component Society shall consider all complaints and inquiries properly filed with the Society in a timely manner and shall render its advice within a reasonable period of time following the receipt of a properly submitted complaint or inquiry. In the event the component Society shall fail to act in a timely fashion, as required in its rules of procedure, the party submitting the complaint or inquiry may petition the Peer Review Appeals Committee of the Illinois State Medical Society, as provided for hereinafter, to take jurisdiction of the complaint or inquiry.

D. *Appeals*—Such parties to the proceedings as delineated below, conducted by the component society may petition the Peer Review Appeals Committee of the Illinois State Medical Society to review certain local proceedings of the component society of district committee. A petition for an appeal must set forth one of the following grounds as a basis for the appeal:
 1. PROCEDURAL ERROR—The peer review proceeding was not conducted in accordance with written rules established by the component society, district committee, or the Illinois State Medical Society.
 2. BIAS—The proceeding was conducted in a biased or arbitrary manner.
 3. INCOMPLETE INFORMATION—If information not available to the component society or district committee is submitted to the State Peer Review Appeals Committee, the committee will first determine the relevancy of the new information. The case will be referred to the component society or district committee for reconsideration if the information is deemed to be pertinent and significant by the State Committee.

A member of the Illinois State Medical Society, who is a party to a peer review proceeding and who has received a final determination from the component Society, may file an appeal with the State Peer Review Appeals Committee, in accordance with Section D, as stated above, as a matter of right. A patient who brings a complaint shall enjoy the privilege of petitioning the State Committee to review the decision of a component Society and the State Committee shall, in its sole discretion, determine whether or not to accept the case on appeal. No other parties shall enjoy the privilege to appeal a decision of the component Society.

In the event of an appeal to the Illinois State Medical Society, the component Society shall send to the Illinois State Medical Society a copy of the complaint, the exhibits and the findings and recommendations of the component Society or District Committee. The right to appeal to the Illinois State Medical Society Peer Review Appeals Committee shall be limited to 30 days after the decision of the component Society or District Committee, unless the appellant can provide an acceptable reason for additional time.

PART 3—DISTRICT COMMITTEE

The delegates in each Illinois State Medical Society district, except in a single county district, shall establish a District Peer Review Committee to function in those instances when the component Society chooses to delegate to its District Peer Review Committee the responsibility to perform the review functions set forth in this Chapter. Upon completion of hearings of each complaint or inquiry referred to it by the component Society, the District Committee shall render its findings and recommendations to the component Society for affirmation. The District Peer Review Committee shall also consider complaints or inquiries assigned to it by the Illinois State Medical Society Peer Review Appeals Committee in those instances when it is determined by the State Committee that a component Society has failed to act in a timely fashion on a peer review complaint or inquiry submitted to it.

PART 4—ILLINOIS STATE MEDICAL SOCIETY PROCEDURES

A. There shall be created a Peer Review Appeals Committee, appointed by and reporting directly to the Board of Trustees. The Committee shall consist of seven members who shall serve one-year terms but, in no event, more than five consecutive one-year terms. Vacancies shall be filled by appointment by the Board.

 The Peer Review Appeals Committee shall review appeals of decisions of component or district peer review committees in accordance with the provisions of Part 2 (D) of this chapter. The state committee shall determine the validity of the alleged grounds and, if found valid, remand the case to the local or district committee for a rehearing. If the alleged grounds are found invalid, the decision of the district or county committee shall be deemed to be reaffirmed. The decision of the Peer Review Appeals Committee shall be forwarded first to the county or district committee and then to the appellant. The state committee shall have authority to assign cases to district peer review committees in accordance with Part 3 of this chapter. Decisions of the state committee shall be final.

B. The State Peer Review Appeals Committee shall adopt appropriate rules for the conduct of its business and shall act on all appropriately filed appeals in a timely manner. The State Committee shall notify the appropriate component Society of its decision in a given case prior to its notification of the parties to the appeal.

C. If, in the judgment of the State Committee, a matter submitted to it on appeal is deemed to be more appropriately treated as an ethical relations issue, the Committee shall refer that case for disposition to the Judicial Panel, created under Chapter XI of these Bylaws.

CHAPTER XIII. MISCELLANEOUS

The fiscal year of this Society shall be from January 1 to December 31 inclusive.

CHAPTER XIV. AMENDMENTS

The House of Delegates may amend any article of these Bylaws by a two-thirds vote of the delegates present at any meeting, provided that such amendment shall not be acted upon before the day following that on which it was introduced.

CHAPTER XV. PARLIAMENTARY PROCEDURES

For those matters not covered by the Constitution and Bylaws of the Illinois State Medical Society, Sturgis Standard Code of Parliamentary Procedure, Current Edition, shall be the guide for conduct of meetings of the House of Delegates, Board of Trustees and all councils and committees.

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1981-1982
Policy Manual of the Illinois State Medical Society

"Policy statements shall be defined as guidelines for the management of the Illinois State Medical Society affairs, based upon prudence, sound judgment and experience."

"Rules and regulations may be prepared by the Board of Trustees or by committees, for use in the implementation of policy."

This manual shall be a guide for officers, AMA delegates and alternate delegates, trustees, committee chairmen and headquarters staff to the stand taken by the House of Delegates of the Illinois State Medical Society on all issues involving Society policy.

Its statements shall combine and reconcile the best expressions made on all phases of policy involving the House of Delegates, the Board of Trustees and the various committees.

All policy statements (except those involving the funds of the Society) shall have the approval of the House of Delegates, since the Constitution and Bylaws provide in ARTICLE V:

"The House of Delegates shall set the basic policy and philosophy of the Society."

All policy statements developed during the interval between meetings of the House shall be submitted at its next meeting

for action. The House may:

(1) approve, amend, or reject—
(2) refer the statement to the Board for reconsideration and subsequent report—
(3) remand the statement to the committee from which it came for further study and report.

Policy statements for the consideration of the House must be presented in resolution form. A member of the Illinois State Medical Society may propose policy by requesting any delegate to submit an appropriate resolution. The Policy Committee will develop policy statements from actions of the House of Delegates and, after approval by the Board of Trustees, the statements will be published in this Policy Manual.

Temporary policy between meetings of the House is determined by the Board. Committees may request Board consideration at any time.

Established policy must prevail until majority action by the House of Delegates has rescinded or reversed the statements. This represents "majority rule" and must be followed closely to preserve the democratic process.

PROFESSIONAL POLICIES

Abortion

The decision to perform an abortion is a medical matter to be determined by agreement between the patient and the physician. Abortions must be performed in conformance with state and federal law and current medical standards, and when so performed shall not be considered unethical. Physicians shall not be required to perform or participate in an abortion by hospital regulations or any other institutional requirement.
(Amended, 1980 Annual Meeting)

Acupuncture

Acupuncture is a surgical procedure and its practice shall be limited to physicians licensed to practice medicine in all of its branches and to dentists.
(1975 Annual Meeting—Reviewed by Board 1980)

Advertising Guidelines, Physician Professional

In keeping with the Principles of Medical Ethics, as well as rules of law, the following advertising guidelines are adopted:

I. General
These guidelines shall apply to solo practitioners and groups of physicians, including medical clinics, HMOs, and other physician-operated facilities. The medical society recommends that these guidelines be suggested for hospitals and other health care institutions. The medical society does not look with favor upon advertisements which promote or produce unfair competition.

II. Acceptable Professional Identification
1. Name, with earned degree(s)
2. Office address and telephone
3. Home address and telephone
4. Answering service
5. Office hours
6. Medical specialization
7. Board certification
8. Type of practice (group, solo) and affiliation, so long as such identification is not misleading
9. Hospital affiliation
10. Foreign language competence
11. Usual and customary fees, for routine medical service. Such fee identification must include notification that fees may be adjusted in the event that complications or unforseen circumstances arise. The usual and customary fee quoted shall be that fee charged to the majority of patients seeking the same basic service. Such fee identification must not be misleading. Average charges may not be stated.
12. Public announcement of changes in any of the above

III. Professionally Unacceptable
1. Testimonials or anecdotal reports of medical practice success
2. Claims of superior quality of care
3. Fee comparisons of available services with those of other licensed physicians or medical clinics
4. Listing of professional service which the offerer is not qualified to provide
5. Statements which contain false, fraudulent, deceptive or misleading material
6. Warranties or guarantees of success or unsuccessful therapy
7. Statements which play upon the fears and vanities of the public
8. Display or similar advertising that may serve to mislead or misinform the public
9. Solicitation of media coverage of medical services by means of "news stories" designed for personal or financial gain

IV. Media Guidelines
1. Newspapers and magazines
 a. Type size shall be that text type used in the publication
 b. Use of any ornaments, embellishments, or symbols is prohibited
2. Professional or business cards, and office signs giving allowable information are permissible
3. Health care services directories (including telephone directories) are subject to the same policies as stated under newspapers and magazines above

(1979 Annual Meeting)

Alcoholism

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression, and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational or social adjustments as a direct consequence of persistent and excessive use of alcohol. Insurance companies should include appropriate coverage for alcoholism. Physicians and their hospitals are encouraged to actively participate in providing services for alcoholics.
(Amended, 1980 Annual Meeting)

Alcoholism Education

The Illinois State Medical Society supports the concept that medical schools and hospital training programs should expand instruction of students in the treatment of acute and chronic alcoholism, as well as its cause and prevention; that physicians and recognized community service agencies should enlarge their services to include treatment and counseling of alcoholics and their families, and, where appropriate, collaborate with recognized alcohol treatment programs; that education programs aimed at alcohol abusers who are drivers should be encouraged, and legal restrictions should be continued to prevent them from holding drivers' licenses; that education of the public (at all age levels) regarding the nature of alcohol and its physiologic and psychologic effects, as well as socio-

economic impacts, should be encouraged.
(Amended, 1980 Annual Meeting)

Ambulance Services

All ambulance services should meet minimum standards as established by appropriate authorities in the field. ISMS should offer its expertise and work to ensure that ambulance services meet these standards.
(Amended, 1980 Annual Meeting)

Anaphylactic Reactions to Insect Stings

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.
(1981 Annual Meeting)

Assessments

Medical staffs are reminded that hospitals do not have the privilege or the right to make compulsory assessments on individual members of the medical staff for building funds or other hospital programs, nor to demand an audit of staff members' personal financial records as a requisite for staff appointments.
(Amended, 1980 Annual Meeting)

Athletic Programs

The medical profession should provide input into the structuring of athletic programs in an effort to minimize physical injuries and inappropriate emotional stress and to insure proper treatment.
(Amended, 1980 Interim Meeting)

Audits and Surveys

ISMS recognizes the necessity of audits and surveys to review the appropriateness of medical services rendered. However, respect for personal privacy and confidentiality must be maintained with utmost priority under all circumstances. Additionally, local medical staff audits and determinations as to management must be respected. In this regard, ISMS recognizes audit processes as performed by organizations who have demonstrated compliance with the aforementioned principles. In contrast, audits and surveys not performed by recognized organizations, or those performed in violation of the above principles, will not be condoned.
(Amended, 1980 Interim Meeting)

Autopsies, Declining Number of

Because the autopsy has educational benefits for medical science as well as the family of the deceased individual, ISMS encourages its members to seek family approval for the postmortem examination in all cases of death.
(1978 Interim Meeting)

Birth Control

The preventive medicine approach to the problem of unwanted pregnancies should be encouraged through family life education in the schools, wider dissemination of family planning information, including birth control information and devices, and encouragement of research in population control methods.
(Reviewed, 1980)

Blood Availability

The Illinois State Medical Society encourages component societies to support abolition of blood bank replacement deposit fees (often referred to as penalty or non-replacement fees).

The Illinois State Medical Society and its component societies encourage hospitals and any other facilities to affiliate with a regional blood replacement center in their areas.

The Illinois State Medical Society and its component societies should assist appropriate organizations in establishing a regionally coordinated blood banking system throughout the state and areas contiguous to the state.
(1979 Annual Meeting)

Blood Services

Inasmuch as blood services affect the entire community, the county medical society should be encouraged to become involved and should have input in blood bank activities serving its county.
(Amended, 1980 Interim Meeting)

Cardiopulmonary Resuscitation

ISMS encourages basic cardiac life support training in Illinois high schools.
(1981 Annual Meeting)

Confidentiality

Communications received in confidence by physicians from patients are privileged: the privilege is that of the patient and the physician is the guardian of the privilege and must not betray it. Current day social values dictate that privileged communication must be continued in accomplishment of the treatment of human illness. Section IV of the Principles of Medical Ethics states that: "A physician shall respect the rights of patients and shall safeguard patient confidences within the constraints of the law." The Illinois State Medical Society re-affirms its belief in this principle and supports activities to guarantee continuation of privacy, while recognizing the need for collection of statistical data and enforcement activities in the public good.

The Illinois State Medical Society supports the concept of confidentiality of the doctor-patient relationship as it relates to the ambulatory patient record and will take an active role in uncovering any violation of the doctor-patient relationship by officials and personnel of review organizations and will take whatever steps are necessary to eliminate the breach of confidence.

ISMS is in opposition to the use of the Social Security number as a universal number identifier.
(Reviewed, 1981)

Continuing Education

Continuing education is one of the basic purposes of the Illinois State Medical Society for scientific advancement, humanization of medicine, improvement of medical public relations, and development of cooperation and rapport with the public. The Society should continue to support the multifaceted approach to continuing medical education as now endorsed by the Illinois Council on Continuing Medical Education.

ISMS will act as an accrediting agency under the policies of the Accreditation Council for Continuing Medical Education as established by the organizations comprising the Council for Medical Affairs. The Illinois State Medical Society should have the primary role in accrediting of quality continuing medical education programs in order to assure that members have access to CME opportunities which are in conformance with licensing regulations of the State of Illinois.

Physicians are encouraged to analyze their individual learning needs before registering for CME courses.

Financial support for the Illinois Council on Continuing Medical Education is provided by the Board of Trustees of

ISMS. ICCME shall prepare an annual financial report for the House of Delegates indicating (a) major sources of income, (b) major categories of expenditure and (c) a proposed budget for the year in which the House is meeting.

All members should be encouraged to participate in the AMA Physician Recognition Award, as presently constituted, or its equivalent.

Sponsors of continuing medical education courses should provide full disclosure of materials, methods, objectives and evaluation procedures of offered courses. Accrediting body and category of credit should be stated.
(Amended, 1981 Annual Meeting

Cost Containment

ISMS endorses the Voluntary Effort of American physicians and hospitals as responsible private sector activity to restrain hospital costs without arbitrary limits or governmental intervention, and it endorses the AMA president's call for physicians to help moderate care costs.

ISMS supports the concept of voluntary planning. ISMS should continue monitoring of planning legislation as to costs, benefits, and effectiveness; and encourage establishment of equitable techniques for administration of federal requirements. ISMS opposes imposition of the public utility type of regulation of the medical profession, whether institutional providers or private physicians. Certificate of need, as a cost containment mechanism, is a non-proven concept and requires continued evaluation.

"Decertification" or conversion to other use of excessive facilities should be on a voluntary and trial basis before final implementation.

The development of appropriate policies and mechanisms that lead to continuity, coordination, and continuous availability of patient care, including appropriate professional preventive care and appropriate early-detection screening services should be encouraged. The appropriateness of a service, test or treatment should be the primary factor in considering its necessity rather than the cost.

Regulatory systems to certify and monitor the performance of insurance carriers, mutual insurance companies and other organizations financing health care services should be established to assure fiscal responsibility and accurate representation of premium or capitation costs and benefits that will not restrict development of innovative approaches to benefit coverage.
(1978 Interim Meeting)

Current Procedural Terminology

The Illinois State Medical Society endorses the American Medical Association's Current Procedural Terminology and encourages its use by Illinois physicians.
(1977 Annual Meeting)

Death, Legal Definition of

ISMS will not support any legislative proposal which seeks to define death unless it provides that, based upon usual and reasonable standards of medical practice, death has occured when it is determined by a doctor of medicine that a person has experienced the permanent and irreversible cessation of the integrated functioning of the respiratory, circulatory and nervous system, according to the following standards:

(a) The irreversible cessation of spontaneous respiratory and circulatory functions; or
(b) if artificial means of support preclude reliance on item (a), the irreversible cessation of spontaneous brain function, which may be confirmed by a flat (isoelectric) electroencephalographic tracing in the absence of hypothermia and of barbiturate and other nervous system depressants.

(1977 Annual Meeting)

Death With Dignity

The Illinois State Medical Society will continue to oppose death with dignity, right-to-die and similar legislation, based upon what must necessarily be a private matter between physician and patient. If passage of such legislation is imminent, it must provide immunity from civil and criminal penalties for physicians who act in good faith and in accordance with accepted medical practice and must not require physicians to act in violation of their own personal beliefs, morals and conscience.
(Amended, 1981 Annual Meeting)

Disaster Control

All medical societies should cooperate with and contribute to disaster plans in their communities.
(Amended, 1980 Annual Meeting)

Drugs, Prescriptions

Prescription drugs may be dispensed only upon the authorization of a physician licensed to practice medicine in all its branches. Public health departments should not conduct drug dispensing and distribution programs without direct physician supervision of patients receiving medication.

Generic drug substitution may be considered within legal limits.

The package insert labeling pharmaceutical preparations is a guide for the clinical application of the product and should not be used as an absolute standard limiting the practice of medicine.
(Amended, 1981 Annual Meeting)

Electromyoneurographic Procedures and Examinations

Clinical electromyoneurographic procedures and examinations, which inherently involve medical interpretations, descriptions of findings, and rendering of diagnostic opinions, should be performed only by physicians licensed to practice medicine in all its branches and trained in these procedures.
(1976 Annual Meeting—Reviewed by Board 1981)

Emergency Medical Care, Provision of

Emergency care should be provided regardless of the ability of the patient to pay. Physicians should be aware of the protection afforded them by the Good Samaritan provisions of the Illinois Medical Practice Act.

Insurance plans which cover emergency medical services should pay for such services regardless of where they are rendered.
(Amended, 1981 Annual Meeting)

Ethics

It is ethical for physicians to associate professionally with whom they wish, acknowledging always that there is no compromise on the historically noble goals of honesty, competence, compassion, respect for dignity, furtherance of knowledge, safeguarding of confidence and service to mankind, and with due regard to modern medical science.
(1979 Interim Meeting)

Examinations

All physical examinations should be performed in the physician's office. No examinations should be conducted on a group basis unless authorization has been given by the local

county medical society in a single instance or for a specific purpose.

This general statement does not apply to the industrial or occupational health physician in his in-patient activities.
(1966 Annual Meeting—Reviewed by Board 1980)

Experimental Medical Procedures

With respect to experimental medical procedures, physicians must adhere to and affirm the following:

Accepted ethical standards;

The codified regulations of the Department of Health and Human Services as specified in Title 45 USC, Sec. 46;

Appropriate Illinois statutory or regulatory requirements.
(Amended 1981 Annual Meeting)

Eyes

Only physicians licensed to practice medicine in all its branches are qualified to prescribe or use eye medications; only such physicians should continue to be the primary entry-point for eye care. ISMS vigorously opposes any attempt in Illinois to give optometrists a license to prescribe or use medications or to serve as a primary entry-point in the provision of eye care.
(1976 Annual Meeting—Reviewed by Board 1980)

55 M.P.H. Speed Limit

The Illinois State Medical Society opposes an increase in the 55 mile per hour speed limit.
(1981 Annual Meeting)

Foundations for Medical Care

The Illinois Foundation for Medical Care is a not-for-profit corporation established to provide physicians with leadership roles in modifying health care delivery in their communities, thus assuring quality care at reasonable cost.

The Illinois Foundation for Medical Care is completely accountable only to the House of Delegates, through the Board of Trustees of ISMS, and to each component society of ISMS.

Establishment of autonomous county and/or multi-county foundations under the sponsorship of local medical societies is encouraged and, together, local and state foundations shall provide a mechanism through which foundation-sponsored programs can be developed and administered throughout the state.

The Illinois Foundation for Medical Care is authorized to investigate and, if economically feasible, to implement programs for supporting physician organizations endorsed by constituent medical societies. Such support is to be in the areas of data needs and other specialized activities, such as statewide co-ordination, statistical analysis, co-ordinated negotiations and support of related state level organizations, utilizing public, governmental or private funds to reimburse the foundation for such activities. Specifically, the IFMC Board is authorized to investigate the feasibility of becoming a statewide support center for physician organizations endorsed by constituent medical societies and to provide administrative support, data processing and specialized services to such physician organizations.
(1977 Interim Meeting)

Freedom of Choice

The mutual right of physicians and patients to exercise freedom of choice in medical matters shall be maintained. This includes the right of the patient to choose the physician by whom he will be served, and the right of the physician (except in emergencies) to a corresponding freedom of choice.

All members of the Illinois State Medical Society enjoy the same rights and privileges and are bound by the same obligations and standards of professional conduct.

ISMS supports the concept of second opinion—only via the usual and customary referral pathways guaranteeing the free choice of physicians.
(1976 Interim Meeting—Reviewed by Board 1981)

Governmentally Supported Health Facilities

ISMS should not facilitate the development of governmentally-supported Health Maintenance Organizations or similar practice alternatives which would be discriminatory against the private or group practice of medicine.
(1978 Annual Meeting)

Health Care Costs

The public should be educated concerning the difference between "health care costs" and "medical care costs." Members of the profession should cooperate with the various ancillary groups and should be able to explain the cost factors involved in total care.

ISMS encourages its members to be aware of the cost of hospital services, supplies and drugs and encourages physicians to receive and review the hospital bill of each patient he hospitalizes as a voluntary step toward cost containment of health care.

ISMS is unalterably opposed to governmental control of hospital costs and physicians' fees and reaffirms its faith in the private enterprise system which has made the United States great and strong and which seeks to make health care available to everybody.

The Illinois State Medical Society encourages cost sharing by patients in all medical care reimbursement plans.
(1977 Interim Meeting)

Health Careers

All capable and worthy individuals interested in medicine as a career shall be encouraged and assisted by the Illinois State Medical Society. Those interested in paramedical fields shall be provided with all pertinent information.
(1967 Annual Meeting—Reviewed by Board 1980)

Health Insurance, Governmental Programs

The Illinois State Medical Society is opposed to compulsory governmentally-mandated national health insurance plans and will continue to point out its dangers and disadvantages to the public, including those in which quality of care is compromised.

It is opposed to national compulsory catastrophic health insurance.

Governmental health insurance benefits for mental illness should be comparable to benefits for any other medical condition.

Governmental health insurance programs providing reimbursement for medical services under the direction of practioners other than doctors of medicine or osteopathic medicine should establish a separate category for such reimbursement, with separate payment, and be optional to the insured.

ISMS will actively oppose any state or federal legislation which proposes reimbursement under health insurance programs of psychologists, social workers or any group of in-

dividual practitioners without medical supervision.
(Amended, 1979 Interim Meeting)

Health Insurance, Voluntary Plans

ISMS endorses the principle of voluntary health insurance. Fixed fee schedules should be recognized as indemnification to the patient and not necessarily payment in full.

The Illinois State Medical Society supports the concept of increased insurance coverage for out-patient diagnostic tests.

It supports the policy of a tax credit or deduction for the premium expense of catastrophic medical insurance and endorses the principle that, under federal rules and regulations, the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible.

Inasmuch as the fee coverage by insurance plans may not cover the full fee of the physician, the physician is encouraged to develop a prior agreement with the patient, such as the "Statement of Understanding." This will outline to the patient his individual responsibility for the physician's fee.

ISMS objects to third party carriers interfering with the practice of medicine and the patient-physician relationship by:

Implying to patients that physician's charges above insurance benefit allowances are excessive;

Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;

Suggesting that physicians perform alternative surgical procedures;

Instituting utilization review of hospital patients in the private sector which by-passes local physician review mechanisms;

Discriminating against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

ISMS endorses long-held principles that:

A contractual relationship that exists between a patient and a third party does not involve the physician (unless the physician has agreed to such involvement); and

The third party is not involved in the contract existing between the patient and his/her physician (unless such involvement has been agreed to by both patient and the physician).

(Amended, 1981 Annual Meeting)

Health Planning

ISMS urges physician participation in the health planning process at all levels, with strong emphasis on planning at the local community level. ISMS supports health planning at the local level, and opposes centralized health planning.
(1980 Annual Meeting)

Health Screening by Allied Health Personnel

Health evaluation, to be adequate, must include a physical examination only by or under the direct supervision of a physician licensed to practice medicine in all of its branches with physician interpretation of the appropriateness and reliability of various screening procedures used.
(1974 Annual Meeting—Reviewed by Board 1980)

Health Systems Agencies

The Illinois State Medical Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim measure, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with federal SHPDA designated criteria.
(1981 Annual Meeting)

HSA Fund Solicitation

The Illinois State Medical Society is opposed to outside fund solicitation by Health Systems Agencies; for such practices may affect the objectivity of the organization.
(1980 Annual Meeting)

Hearing Disorders

Physicians licensed to practice medicine in all its branches remain the primary entry point for the care of patients with hearing impairment.
(1977 Annual Meeting)

Hospices

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, 7 days a week, through either inpatient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.
(1981 Annual Meeting)

Hospitals

Physicians should sponsor and assist in the development of all medical staff committees within the hospital.

The local medical profession should cooperate to achieve the accreditation of all eligible hospitals, and should encourage the stabilization or reduction of hospital costs in all areas where they have authority.

All county medical societies are encouraged to form standing committees composed of medical society officers and representative officers of all hospital staffs in their areas to guarantee a free exchange of information between the medical society and hospital staffs related to activities of hospitals, medical organizations, governmental and quasi-governmental agencies in their community.

The Illinois State Medical Society encourages the development of local peer review plans for appropriate review of utilization of hospital emergency rooms.
(1977 Annual Meeting)

Hospital—Medical Staff—Management Relationship

Any proposal or arrangement between institutional management and medical staffs should not conflict with the Principles of Medical Ethics or abridge the property right endowed upon the individual physicians by the Illinois Department of Registration and Education. The practice of medicine is the physician's legal prerogative and responsibility. To insure the quality of medical care, each hospital has the obligation to cooperate with and assist its medical staff in implementing procedures by which the quality of medical care in that hospital may be maintained by and through its medical staff.

ISMS is opposed to hospital actions which unilaterally stipulate that professional liability insurance is a prerequisite for membership on a medical staff. If a hospital proposes to require evidence of professional liability insurance as a condition of membership on a medical staff, such condition should be in accord with rules and requirements as established by

the organized medical staff of the hospital in cooperation with the hospital board of trustees. To protect their assets, members of a hospital medical staff should be assured of the adequacy (scope and amount) of professional liability coverage carried by the hospital as a reciprocal disclosure between the staff and hospitals.

Results of recertification examinations should not be the sole criterion used by hospital governing bodies and hospital medical staffs in the granting of clinical privileges.
(1978 Annual Meeting)

Hospital Medical Staff Privileges

Members of a medical staff should receive due process as spelled out by the Bylaws of the medical staff before their medical staff privileges can be terminated. The Illinois State Medical Society supports physicians in their right to continue to practice in a community or hospital as long as they follow the bylaws of the medical staff and maintain the highest quality of medical practice to their patients unless good cause can be shown that continuation of the physician in practice is not in the best interest of his/her patients.
(1980 Annual Meeting)

IDPA Drug Manual

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bioequivalence.
(1981 Annual Meeting)

Immunization Programs

Illinois residents should be provided access to all medically indicated immunization. Physicians are requested to provide this protection or to encourage the local public health agency to perform this function, and to encourage enforcement of current immunization laws. In addition, physicians should be encouraged to participate in epidemiological studies (especially as related to "search and destroy" methods for communicable diseases) which have been endorsed by the local or state medical society.

Every school district should be consulted by health departments planning any mass immunization campaign. In counties where there is no public health department, the Illinois Department of Public Health should contact either the county medical society or local physicians (whichever is appropriate) for coordination of the immunization program.

The Illinois Department of Public Health or the Illinois State Medical Society should institute whatever is necessary, including appropriate state indemnification or "exemption from liability" legislation, to assume or alter the liability responsibility during any mass immunization program.

If private facilities are utilized during a mass immunization campaign, normal reimbursement procedures may be employed, but no charge shall be made for the cost of vaccine paid for by the federal government.
(Amended, 1981 Annual Meeting)

Indigent, The Care of the

Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and only in conjunction with the other levels of government in the order above.

The determination of medical needs should be made by a physician. The determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved.
(Prior to 1965—Reviewed by Board 1980)

Laboratories

All laboratories providing medical data should be under the direct supervision of a physician currently licensed to practice medicine in all its branches.
(Amended, 1980 Interim Meeting)

Manipulative Casting of Congenital Deformities of the Extremities

Manipulative casting of congenital deformities of the extremities, whether performed in the office or hospital, is considered a surgical procedure.
(1981 Annual Meeting)

Marijuana

ISMS does not endorse the legalization of the possession or use of marijuana.

Since the medical and psychiatric knowledge concerning the short-term and long-term effects of cannabis is very limited, medical research should be supported by public and private resources of the State of Illinois.
(1976 Annual Meeting—Reviewed by Board 1980)

Medical Diagnosis and Treatment

While the Illinois State Medical Society recognizes the interests of third parties in patient care, it categorically maintains that prognosis and length of treatment must always be individualized to the patient, the diagnosis, and community standards for medical care.
(Amended, 1980 Annual Meeting)

Medical Education—Schools

The Illinois State Medical Society supports development of innovative programs in medical education maintaining a firm foundation in the basic sciences.

The Illinois State Medical Society favors admission of students into medical schools on the basis of their ability to be good medical students and physicians.

ISMS supports the concept that Illinois medical students, whose medical education is supported by Illinois tax money, be encouraged to remain in Illinois to practice.
(Amended, 1980 Annual Meeting)

Medical Examiners

ISMS favors a medical examiner system throughout the state in preference to a coronor system, wherever practical.
(1971 Annual Meeting—Reviewed by Board 1980)

Medical Liability Insurance Premiums

The Illinois State Medical Society supports the concept that premium schedules for medical liability insurance should be based on the actual cost and risk of providing that insurance to each individual group or category.
(1979 Annual Meeting)

Medical Psychotherapy

Medical psychotherapy is a medical procedure for the treatment of mental and physical ailments or illness. It involves verbal and non-verbal communications with the patient, and

always includes continuing medical diagnostic evaluation and drug management as indicated. Medical psychotherapy may be performed only by a physician licensed to practice medicine in all of its branches.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

Unless physicians appointed to the boards and committees of other organizations are nominated by their local county medical society, such physicians shall not be considered "representative" of the medical community.
(Amended 1978 Interim Meeting)

Medical Testimony, Expert Witnesses

An expert medical witness is defined as a physician licensed to practice medicine in all its branches having a basic educational and professional knowledge as a general foundation for testimony and, in addition, having special expertise, current personal experience, practical familiarity, and technical knowledge of the problems that are being considered, as well as alternative forms of treatment, and is currently active in the practice of the medical subject under discussion.

Any physician licensed to practice medicine in all its branches who functions as an expert witness, must satisfy the definition of an expert witness, that the definition be a matter of policy, and that it be considered unethical conduct on the part of any physician appearing as an expert witness who does not meet this standard.
(1977 Annual Meeting, Reviewed, 1981)

Medical Testimony, Impartial

The ends of justice are served when impartial medical witnesses are available to the judiciary. The ISMS supports this concept and offers its assistance in the provision of impartial medical testimony.
(Amended, 1980 Annual Meeting)

Medicare Assignments

The Illinois State Medical Society supports the concept that Medicare payments be made directly to physicians who choose to accept Medicare assignments. When a Medicare payment is incorrectly made directly to the patient, Medicare should make full payment to the physician who has chosen to accept Medicare assignments as soon as the error is verified.
(1980 Interim Meeting)

Mental Health

The Illinois State Medical Society strongly opposes a double standard of care in state hospitals.

The Department of Mental Health and Developmental Disabilities (DMHDD) should adopt a firm policy for the continuing education of physicians employed by its various mental health centers, allocating state funds necessary to provide high-quality continuing medical education relevant to the needs of these physicians.

Each constituent county society should cooperate fully with and support local units of the DMHDD in their patient care efforts, specifically seeking to encourage:

1. Local general hospitals to accept mental health patients who can be helped by short-term treatment, leaving to state institutions the responsibility for such chronic and long-term cases which local hospitals cannot presently handle.
2. Local general hospitals and practitioners to retain in their own care those geriatric patients who have ailments of primarily a physical nature.
3. Local physicians, local hospitals, and local skilled nursing facilities to provide primary and secondary care for psychiatric problems to the extent possible; given facilities and physician-time available.
4. Arrangements for emergency mental health care, *i.e.*, crisis intervention, to be available areawide.

All physician or other health service provided to the DMHDD, other than that by fulltime employees, should be on the same fee-for-service basis as any other medical service which is paid by the patient or third party insurer.

Involuntary psychiatric hospital certification, initial or subsequent, must without exception remain the responsibility of a physician licensed to practice medicine in all of its branches and a physician licensed to practice medicine in all of its branches should be required to certify the discharge of any patient from a psychiatric institution.
(1977 Annual Meeting, Reviewed by Board, 1981)

Multiphasic Screening

Multiphasic screening tests (including brief physical examination and multiple automated laboratory tests) are accepted procedures for health evaluation when carried out in a scientific manner and in conformance with laws of the State of Illinois and regulations of the Department of Public Health. The persons participating in or sponsoring these activities should be advised that: (1) Abnormal findings do not necessarily indicate a disease exists; such a determination must be made by a physician; (2) The absence of abnormal findings does not necessarily indicate the patient is free of disease; and (3) That such screenings should be done under the guidance of local medical societies or other recognized medical authorities.
(Amended 1980 Interim Meeting)

Nurses-Shortage

A severe shortage of graduate nurses continues to imperil the provision of quality patient care. The ISMS supports all forms of qualified nursing education and urges that all such schools be encouraged to remain in operation.
(1970 Annual Meeting—Reviewed by Board 1980)

Nursing Homes

Every patient receiving long-term nursing care should have an attending physician who acknowledges his continuing responsibility in writing. Responsible parties, preferably the patient or immediate family, should be urged to select a physician.
(1973 Annual Meeting—Reviewed by Board 1980)

Nutrition

Proper attention to patients' complete nutritional status should be of concern to all physicians. Patient education in the field of nutrition should be a major priority.
(Amended, 1980 Annual Meeting)

Occupational Health

Occupational health is an essential ingredient of employee welfare. The continued adoption and development of occupational health programs in the private and public sectors should be encouraged.
(Amended 1980 Interim Meeting)

Optometric Services

ISMS supports the concept that those performing optometric services in Veterans Administration facilities should be directly responsible to their respective departments of ophthalmology.
(1978 Annual Meeting)

Patient Care Records and Their Availability

Patient care records contain privileged information of confidential nature. Such records are the property of the hospital, clinic or physician. Information contained therein is held in trust by the holder.

In the case of hospital records, patients, patients' attorneys or patients' succeeding physician, upon written patient authorization, have the right of access to hospital records, the ability to review and the right to copy or receive copies. Hospitalized patients may be afforded access to their records upon discharge but not during hospitalization. This access is not afforded in case of psychiatric illness. In the case of non-hospital records, patients' attorney or succeeding physician, but not patients themselves, upon presentation of written patient authorization, have the right of access to said records, with the ability to review and the right to copy and receive copies.

Upon receipt of proper, written authorization from the patient, a copy abstract or summary shall be provided, as required, to legally authorized recipients of such record.

Patient records are utilized by official committees of organized medical staffs or accomplish scientific review, peer review or other patient care improvement. Reports and proceedings of such committees are confidential and shall not be disclosed to any person outside the purview of such committees.

Pursuant to a subpoena for records, a physician is legally required to release medical records in the absence of a signed patient authorization. It is recommended that when records are released, a copy be maintained in the physician's file.

A reasonable charge for record copying service may be made.

Reference may be made 1979, Illinois Revised Statutes, Chapter 48, Section 138.8; Chapter 51, Section 71, 73 and 101; Chapter 91½, Section 800ff.
(Amended 1981 Annual Meeting)

Peer Review

Peer review is the inclusive term for medical review by practicing physicians of the utilization of medical services, quality of care, professional competency and patient relations issues. Medical society peer review shall be conducted at the local level whenever possible. Major ethical relations questions identified during deliberations of the Peer Review Committee shall be appropriately referred.
(1978 Interim Meeting)

Physician Records, Privacy of

The Illinois State Medical Society will take whatever action is necessary to assure that no third party be granted access to the physician's own private medical practice business records, including copies of cancelled checks, cash disbursement journal, leases, contracts, or other confidential business records, without appropriate authority assuring due process.
(1978 Interim Meeting)

Physicians

The term, "Physician," may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches." The goal of the Illinois State Medical Society is to have this definition made a part of the Illinois Medical Practice Act.
(1977 Annual Meeting)

Physician's Assistants

The Illinois State Medical Society recognizes the physician's assistant as a trained health professional who can serve a proper function within the scope of his/her certification and under the direct one-to-one supervision of a physician.
(1980 Annual Meeting)

Prolonging Human Life

Any legislation which proposes statutory restrictions that can intrude into the relationship of the physician and his patient and which may interfere with the physician's ability to use his best judgment and training in caring for his patient is not in the best interest of either the patient or the public and should, therefore, be unrelentingly opposed.
(1976 Annual Meeting, Reviewed by Board, 1981)

Psychosurgery

Psychosurgery refers to those surgical operations which irreversibly destroy brain tissue for the primary purpose of treating mental disorders. Psychosurgery does not include procedures undertaken to treat definable disease states such as tumors, epilepsies, aneurysms and chronic pain syndromes, nor does it include electrical stimulation of the brain, such as electroconvulsive therapy. Psychosurgery should not be performed without adequate documentation of indications, adequate consultation and reasoned consent.
(1975 Annual Meeting—Reviewed by Board 1980)

Public Aid

The "chain of command and procedure" in handling problems arising in the field of public aid shall be from the county to the state advisory committee; then the state advisory committee shall assume the responsibility of making the medical program work and cooperating with the Illinois Department of Public Aid to maintain the best type medical care for the recipients of state aid.

The fees paid by state/federal programs to physicians should be based upon the usual and customary fee concept.

An extensive program of education and rehabilitation should be conducted for the recipients of public aid.

Rehabilitation of all recipients should be of paramount concern.
(1978 Interim Meeting)

Public Health Departments

Public Health is the art and science of maintaining, protecting and improving the health of the people through organized community efforts, including contributions by voluntary health associations, medical societies and other health-oriented groups.

Full-time modern local health departments adequately financed and staffed at the county or multiple county level are highly desirable and, if available, would be capable of providing these services to the people throughout the state. It is of paramount importance that such departments should be established where none now exist and that county medical societies, as well as physicians, should give their wholehearted support.

ISMS encourages and supports the development of local joint committees of county medical societies and county public health departments to review current and proposed public health projects.

ISMS encourages local health departments and component medical societies to delineate the roles of the public and private sectors in providing health and medical services to the community. The following should be considered: 1) coordination and facilitation of direct services which should occur in a manner to avoid duplication of available medical services; 2) the availability of private medical services; 3) the gaps in medical and health services that should be filled by public health activities; and 4) the socio-economic characteristics of the population to be served.
(Amended, 1980 Annual Meeting)

Rehabilitation

All physical rehabilitation activities should be prescribed by a physician and the treatment carried out under the supervision of a physician.

Medical societies should render assistance to public and private agencies regarding rehabilitation facilities to be used and in the selection of patients for these services.

Insurance carriers should be encouraged to include rehabilitation services in their contracts.
(Prior to 1965—Reviewed by Board 1980)

Reimbursement for Medical Care of Psychiatric Illness

Medical care of psychiatric illness should be included in all health insurance policies.
(1980 Annual Meeting)

Reimbursement for Out-Patient Services

Third-party payors should be encouraged to provide coverage for outpatient diagnostic tests and surgery.
(1980 Annual Meeting)

Reimbursement for Treating Medicaid Patients

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of Public Aid recipients.
(1981 Annual Meeting)

Relationship with Third-Party Payors

ISMS should provide guidance, education, communications, and negotiations between the membership and third-party payors.
(1980 Annual Meeting)

Smoking

The Illinois State Medical Society is opposed to the sale of tobacco and tobacco products in hospitals and will encourage medical staff action to make hospitals tobacco smoke-free.

Physicians and their employees should refrain from smoking during patient contacts.

Physicians should give advice and provide literature and signs concerning the health hazards of smoking.

ISMS encourages and supports efforts, legislative and otherwise, to ban or restrict smoking in all public places and the development of appropriate regulations to accomplish this.
(Amended, 1979 Interim Meeting)

Surgery, Reconstructive

Surgery to correct post-surgical deformities is reconstructive surgery.
(1979 Annual Meeting)

Surgery, Second Opinion for

Recognizing that the advisability of surgery or other special therapy can be a matter of opinion, the Illinois State Medical Society (1) reaffirms the right of the patient to seek a second opinion freely from any physician of his/her choice; (2) opposes the concept of mandatory second opinions or the imposition of financial penalties by a third-party payor for not obtaining a second opinion; and (3) supports the concept that, when a second opinion is required by a third-party payor, that second opinion should be at no cost to the patient.
(1979 Annual Meeting)

Third Party Intrusion Into Medical Judgment

Medical judgment and decision-making power of the treating physician must not be abrogated by third party payors. ISMS is opposed to any third party having the power of decision as to medical necessity of services and supplies, including hospitalization, over and above the judgment of the treating physician.
(1978 Annual Meeting)

Usual and Customary or Reasonable Reimbursement

The Illinois State Medical Society endorses the AMA policy on physician reimbursement, which supports only the usual and customary or reasonable concept, rather than any type of negotiated fee schedule.
(1979 Annual Meeting)

Utilization Review

ISMS encourages hospital medical staffs to perform focused utilization review of all patients in selected diagnostic categories, regardless of the source of payment.

ISMS urges all third party payors—private insurance carriers as well as government—to provide reimbursement to hospitals and physicians for time and expense incurred in focused utilization review.
(1978 Interim Meeting)

Veterans Administration

The Illinois State Medical Society continues to support the concept that a Veterans Administration hospital should only be concerned with the needs of those patients with service-connected disabilities.
(Amended, 1980 Annual Meeting)

Violence

The Illinois State Medical Society opposes the ready accessibility to hand guns without evidence of responsibility on the part of the possessor and urges strict enforcement of present federal, state and city laws and that the courts, as well as the legislature, impose maximum penalties on all offenders.

The Illinois State Medical Society will continue to take an active interest in the apprehension and prosecution of those persons committing assaults on physicians, including the offering of rewards and other incentives in the solution of such cases.
(1978 Annual Meeting)

ADMINISTRATIVE POLICIES

AMA-ERF

The AMA-ERF contributions for Illinois graduates shall be distributed to the Illinois medical school from which the member graduated.

The contribution for the balance of the membership shall be distributed to Illinois medical schools in the same proportion as above.

Any member may over-ride this procedure and designate a school of choice by advising ISMS in writing.
(Amended, 1980 Interim Meeting)

Autonomy of County Medical Societies

In all areas, the county medical society shall be autonomous. Actions of any county medical society should conform with the Constitution and Bylaws of the Illinois State Medical Society.
(Amended, 1980 Interim Meeting)

Budgets—(see "Financial Policies")

Committee Appointments

The chairman of the Board of Trustees and the officers of ISMS shall give the trustees an opportunity to recommend physicians from their districts for appointment to various committees. Trustees shall receive the proposed list of committee appointments for their consideration and review prior to the meeting of the Board at which the final committee personnel is to be approved.

Individual tenure on any committee should be limited to a maximum of five years of continuous membership.

Physicians appointed to Illinois State Medical Society committees must be members in good standing of this Society.
(1978 Interim Meeting)

Councils and Committees

It is the policy of the Board of Trustees to encourage evening or weekend meetings of councils and committees at convenient locations to improve membership involvement in council and committee activities.
(1981 Annual Meeting)

Disciplinary Action

The Illinois State Medical Society will immediately communicate any disciplinary action by the Department of Registration and Education to the appropriate county society.
(1980 Interim Meeting)

Dues Approval Procedure

All financial matters involving changes in dues, dues structure, allocation of dues, or levying of assessments in any such manner shall be distributed to all delegates and alternate delegates and to all presidents and secretaries of county medical societies at least thirty days prior to the convening of the House of Delegates
(1980 Annual Meeting)

Election of AMA Delegates

Delegates to the American Medical Association should be elected from those having served first as alternate delegates.
(Amended, 1980 Annual Meeting)

Financial Policies

(1) The Finance Committee is to make budgetary recommendations to the Board of Trustees.

(2) The expenses of any duly elected delegate or alternate delegate attending the meetings of the House of Delegates of the American Medical Association shall not be assumed by the ISMS until he enters his official term of office set by the Constitution and Bylaws of the AMA.

(3) ISMS funds used by members campaigning for elections as AMA officers, trustees or members of councils or committees must be approved by the ISMS Board of Trustees before such funds are spent for election campaign purposes.

(4) The expenses of any official representative of the ISMS attending any authorized meeting shall be determined by the Finance Committee and approved by the Board of Trustees.

(5) Any new project authorized by House action requiring the expenditure of funds must be accompanied by an estimate of the cost and suggested methods of providing the necessary funds.

(6) Budgets submitted to the House by the Board should provide for the ensuing fiscal year.

(7) In addition to fixed reserves, the development of a contingency reserve is desirable.

(8) All financial records shall be available at headquarters office, and may be examined by any member of the Society. A semi-annual summary of the financial statements of the Society shall be mailed to any county society secretary or delegate if requested. A projected budget for the next fiscal year shall be mailed to the members of the House of Delegates at least 30 days prior to the annual convention. These reports shall be in the format customarily used in ordinary corporate practice.
(1977 Annual Meeting)

Honoraria For Officers

The Finance Committee is instructed to evaluate annually the honoraria paid to ISMS officers and to recommend appropriate changes to the Board of Trustees for consideration and action, reporting any changes to the House of Delegates at its next session.
(1978 Annual Meeting)

Illinois Medical Journal

The Publications Committee, with approval of the Board of Trustees, has authority to carry out publication policy. The committee is responsible for screening proposed advertising copy and advertisers, as well as for direction of the editorial content.

ISMS asserts the right to first refusal of original papers presented at programs for which ISMS is primary fiscal sponsor.
(1981 Annual Meeting)

Individual Rights

Since this Society believes that a strong America is a free America, the rights of an individual, or a group of individuals, to openly express themselves cannot be condemned even if one is in complete disagreement, if the laws of the land are not violated. To support such condemnation would be inconsistent with the Society's basic philosophy.
(Prior to 1965—Reviewed by Board 1980)

Informing the Membership

The membership of the Illinois State Medical Society shall

have been properly informed when the following items have been accomplished:

1. Official notice in the *Illinois Medical Journal;*
2. Brief notice in Action Report, outlining the issue and calling attention to the *IMJ* article; and
3. A letter is sent to all county society presidents, secretaries and county executives.

(1977 Annual Meeting)

ISMS Auxiliary

Projects in which the Auxiliary participates shall be approved by the local county medical society.

Requests for cooperation between the Auxiliary and the Illinois State Medical Society should be channeled through the Advisory Committee provided by the Board of Trustees.
(Prior to 1965—Reviewed by Board 1980)

ISMS Candidates for AMA Positions

Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils and committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except in situations wherein positions suddenly become open, and such consultation is impossible.
(1976 Interim Meeting)

Legal Counsel

The legal counsel of the Illinois State Medical Society shall serve the Society at the direction of the Board of Trustees. Counsel shall respond to official inquiries from officers, trustees, committee chairman and county medical societies. Such inquiries shall be channeled through the Board of Trustees.
(Amended, 1980 Annual Meeting)

Legislation

All matters pertaining to state or federal legislation shall be referred to the Governmental Affairs Council for consideration and recommendation prior to Board of Trustees and/or House of Delegates action.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council or Governmental Affairs of the Illinois State Medical Society prior to making a recommendation either to the Board of Trustees or to the House of Delegates.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee.
(1971 Annual Meeting—Reviewed by Board 1980)

Legislative Intrusion into Medical Judgment

The Illinois State Medical Society opposes any and all legislative efforts to interfere with physicians' judgment as to which procedures are appropriate and in the best interest of his or her patients and ISMS will work aggressively to oppose any legislation abridging the physician's prerogatives in this regard.
(1974 Annual Meeting—Reviewed by Board 1980)

Mailing List

The use of the mailing list of ISMS members must be approved by the Board of Trustees.
(Amended, 1980 Annual Meeting)

Medical Representation in Government Planning

In health programs financed by government funding in an Illinois community, there shall be representation at the highest policy level by an official representative of the state society and the appropriate county medical society involved. Remuneration for services in above programs shall follow the policies of the Illinois State Medical Society.

Only those programs which have involved physicians at the local level in the planning and development stages shall be approved by ISMS.

Only physicians appointed to the boards and committees of other organizations who are endorsed by their local county medical society shall be considered "representative" of the medical community.
(1978 Interim Meeting)

Participation in Service Organizations

The Society recommends that physicians affiliate with service clubs, local political action groups and participate to the fullest extent possible in affairs affecting the health and welfare of the residents of Illinois.
(Amended, 1980 Interim Meeting)

Physician Recruitment Service

The Illinois State Medical Society shall coordinate activities connected with recruiting doctors to practice in Illinois. It shall maintain a Physician Recruitment Service to disseminate information about physician-short communities to doctors who have indicated to the service that they wish to relocate in Illinois. It shall take an active role with other organizations in Illinois conducting recruitment activites.
(1980 Annual Meeting)

Polls, Opinion

The Board of Trustees is responsible for ascertaining the opinion of members on critical issues facing the society. Periodic membership opinion polls should be considered as one means of ascertaining member opinion. However, the vote of the House of Delegates shall express the opinion of the majority of the Illinois State Medical Society membership since delegates are the duly elected representatives of their county medical societies and it is the responsibility of the delegates to determine the thinking of their constituents so that their voting will express this opinion. The majority opinion is expressed in the House of Delegates and it should be unnecessary to conduct a membership poll except under very exceptional conditions.
(1976 Interim Meeting)

Press

In order to provide the public with prompt and accurate information on all health-related matters, all county medical

societies are encouraged to cooperate with the local news media.

County medical societies are responsible for providing their local media with information concerning official county society statements or actions, and should serve as a source of information on health issues of local concern.

The state society is solely responsible for disseminating information on its official actions, statements or views of the Illinois State Medical Society on issues with statewide or national implications.
(Amended, 1980 Interim Meeting)

Professional Liability

The Illinois State Medical Society endorses the concept of effective peer review in all matters related to the professional liability of physicians, including the right of individual physicians to appear before appropriate peer review committees responsible for this liability coverage.
(Amended, 1978 Interim Meeting, Reviewed by Board, 1981)

Public Statements

Only officially designated persons may publicly speak for the society. The chairman of the Board of Trustees, at the request of the president, shall designate ISMS spokesmen.

Spokesmen should bear in mind that, as representatives of the society, they should refrain from expressing their personal views. Their public statements should be—to the best of their ability—in consonance with the society's policies and positions.
(1978 Annual Meeting)

Public Statements, Endorsements

No officer, member of the Board of Trustees, council or committee chairman or staff member is permitted (during his term of office or employment) to allow his name and ISMS title to be used in lists endorsing candidates for public office. No one shall use the official Illinois State Medical Society stationery for personal statements of any nature, including the endorsement of any candidate for public office.
(1980 Annual Meeting)

Reference Committee Appointments

Whenever possible at least two members shall be retained on all reference committees for the following year in order to effect continuity of experience.
(1967 Annual Meeting)

Reference Service

County medical societies should establish procedures for referral of patients seeking physician services. It is appropriate to announce the availability of such an activity via the news media as a public service. When any such request is received at the state society office or by any officer of the ISMS, it shall immediately be referred to the secretary of the county medical society involved.
(Amended 1980 Interim Meeting)

Resident Participation at County Level

The Governing Council of the ISMS Resident Physicians Section will serve in an advisory role for component societies planning resident participation at the local level.
(1980 Annual Meeting)

Resident-Student Alternate Delegates to AMA

The Resident Physicians Section and the Medical Student Section shall recommend to the chairman and the secretary of the AMA Delegation the names of residents and students to be appointed to fill any alternate delegate vacancy on a temporary basis.
(1979 Annual Meeting)

Resolutions

Since the relationship between the Illinois State Medical Society and other voluntary physician membership organizations is the responsibility of the Board of Trustees, the Speaker of the House of Delegates shall refer to the Board any resolutions making reference to other voluntary physician membership organizations not affiliated with ISMS.
(1976 Interim Meeting)

Specialty Society Representation on ISMS Councils

For the improvement of communication and the discussion of problems of mutual interest and concern, closer liaison between specialty societies of medicine and the councils of the Board of Trustees is desirable.

Specialty societies represented on the Council on Affiliate Societies shall be invited to submit recommendations for appointment to ISMS councils. Persons so recommended shall be members of both ISMS and the specialty society making the recommendation.
(1979 Annual Meeting)

Uniform Health Insurance Claim Form

The Illinois State Medical Society supports the use of the Health Insurance Claim Form developed by the AMA Council on Medical Service by all insurance carriers and physicians.
(1974 Annual Meeting—Reviewed by Board 1980)

Policy Manual Appendix

Statement of Understanding

(between patient and physician)

I agree that the determination of professional services to be rendered by my doctor and the fees to compensate him for these services are matters concerning my doctor and me. I understand that I have the primary duty and obligation to pay my doctor for his services, notwithstanding any contract I may have with any third party (be it an insurance company, employer, union, government, or the like). Neither my doctor nor I will permit any third party to determine what medical services I need or what fees the doctor should receive in return for these services. Any agreement that either of us may have with any third party shall not affect our doctor-patient relationship and the decisions relating to medical care and fees. Neither my doctor nor I, as his patient, are in any way bound by any contract the other may have with any third party.

ISMS HOUSE OF DELEGATES

OFFICIAL MEMBERS OF THE HOUSE WITH THE RIGHT TO VOTE

Officers of ISMS

President—Fred Z. White
723 N. Second St., Chillicothe 61523
President-Elect—Cyril C. Wiggishoff
25 E. Washington, Chicago 60602
Secretary-Treasurer—Eugene P. Johnson
P.O. Box 68, Casey 62420
First Vice President—Robert P. Johnson
108 Maple Grove, Springfield 62707
Second Vice President—Maynard I. Shapiro
7531 Stony Island, Chicago 60649
Speaker of the House—Clifton L. Reeder
516 Sheridan Rd., Wilmette 60091
Vice Speaker of the House—Julian W. Buser
6600 W. Main, Belleville 62223

Board of Trustees

Chairman, Board of Trustees—Morris T. Friedell
7531 Stony Island, Chicago 60649
1st District—John J. Ring
511 E. Hawley, Mundelein 60060 1984
2nd District—Allan L. Goslin
712 N. Bloomington, Streator 61364 1983
3rd District—Alfred Clementi
675 W. Central Rd.,
Arlington Heights 60005 1982
Audley F. Connor, Jr.
7531 Stony Island Ave., Chicago 60649 1983
Jere Freidheim
3050 S. Wallace, Chicago 60616 1982
Morris T. Friedell
7531 Stony Island, Chicago 60649 1984
Robert C. Hamilton
25 E. Washington, Chicago 60602 1983
Henrietta Herbolsheimer
1700 E. 56th Street, Chicago 60637 1984
Lawrence L. Hirsch
2434 Grace, Chicago 60618 1984
Harold J. Lasky
55 E. Washington, Chicago 60602 1983
Richard Rovner
645 N. Michigan, Suite 920, Chicago 60611 ... 1983
Joseph C. Sherrick
303 E. Superior, Chicago 60611 1983
4th District—George Burke
Rock Island Franciscan Hospital,
2701 17th St., Rock Island 61201 1982
5th District—Robert Prentice
2248 Warson Rd., Springfield 62704 1982
6th District—Robert R. Hartman
1040 College, Jacksonville 62650 1984
7th District—Alfred J. Kiessel
One Powers Lane Place, Decatur 62522 1982
8th District—James Laidlaw
104 W. Clark, Champaign 61820 1982
9th District—Warren D. Tuttle
203 N. Vine, Harrisburg 62946 1984
10th District—Thomas Meirink
8601 W. Main St., Belleville 62223 1984
11th District—Kenneth A. Hurst
52 Bunting Lane, Naperville 60565 1983
12th District—Joseph Perez
5670 E. State, Rockford 61108 1983
Trustee-At-Large—Herschel Browns
4600 N. Ravenswood, Chicago 60640 1982

Representatives of County Societies

A complete listing of delegates and alternates to the ISMS House appears in the convention program. (October issue)

EX-OFFICIO MEMBERS OF THE HOUSE WITHOUT THE RIGHT TO VOTE

Past Presidents

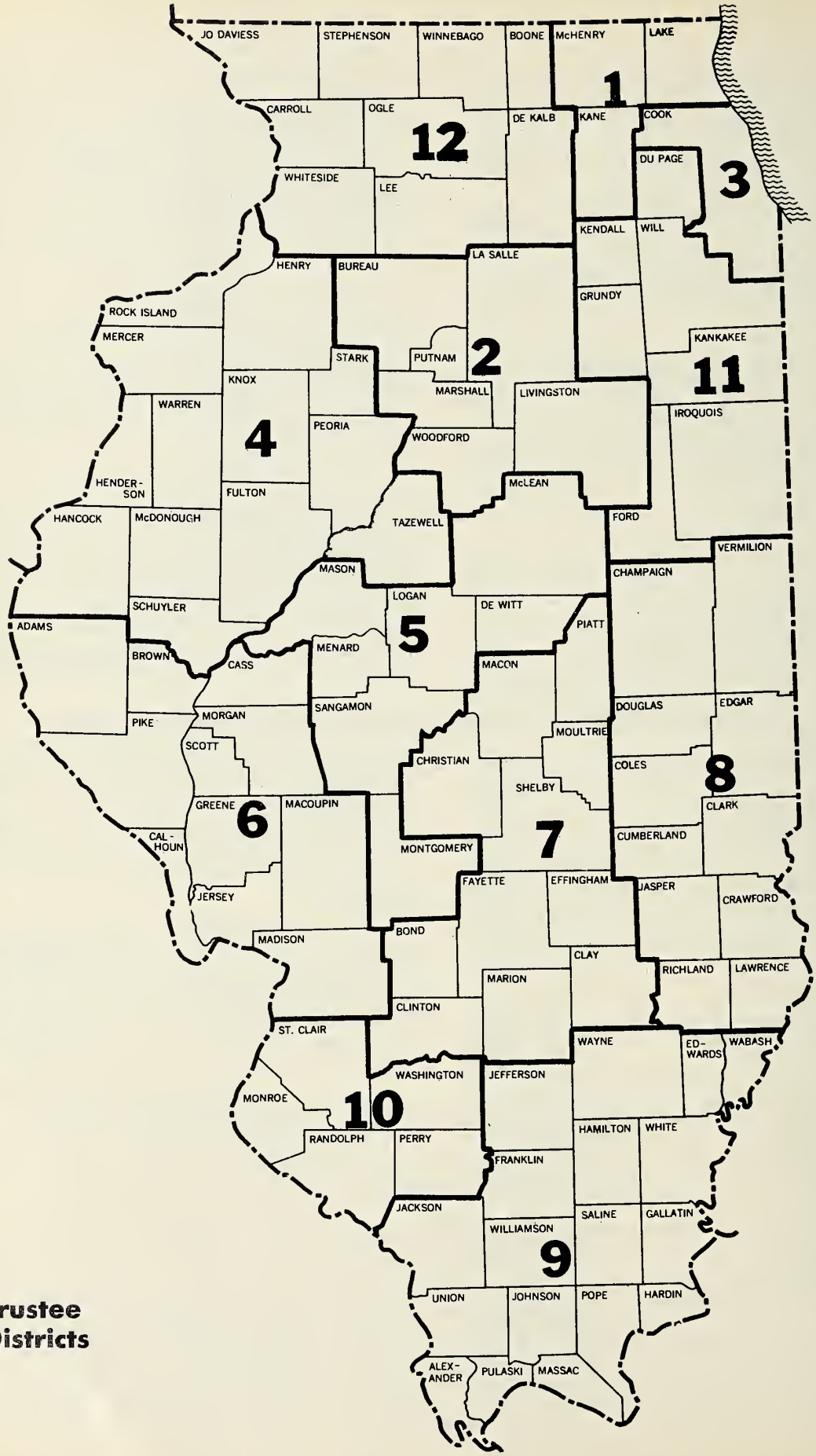
J. Ernest Breed* 1971
Herschel Browns 1981
Edward W. Cannady* 1970
Newton Dupuy* 1968
Harlan English* 1964
David S. Fox* 1979
Edwin S. Hamilton* 1962
H. Close Hesseltine* 1961
J. M. Ingalls 1976
Charles J. Jannings, III 1972
Frank J. Jirka, Jr.* 1973
Fredric D. Lake* 1975
Burtis E. Montgomery* 1966
Caesar Portes* 1967
Jacob E. Reisch (Honorary)* 1979
Willard C. Scrivner* 1974
P. John Seward* 1980
Joseph H. Skom* 1977
Leo P. A. Sweeney* 1953
Philip G. Thomsen* 1969
George T. Wilkins, Jr. 1978
*Also a past trustee or councilor

Past Speakers

Walter C. Bornemeier, Chicago 1962-1964
Edward W. Cannady, Belleville 1965-1967
Maurice M. Hoeltgen, Chicago 1968-1970
Paul W. Sunderland, Gibson City 1971-1973
Andrew J. Brislen, Chicago 1974-1975
James A. McDonald, Geneva 1975-1977
Cyril C. Wiggishoff, Chicago 1977-1979
Robert P. Johnson, Springfield 1979-1981

Past Trustees

Earl H. Blair
Chicago, Trustee of the 3rd District
Walter C. Bornemeier
Chicago, Trustee of the 3rd District
Julian W. Buser
Belleville, Trustee of the 10th District
Raymond DesRosiers
Chicago, Trustee of the 3rd District
Herbert Dexheimer
Belleville, Trustee of the 10th District
Alfred Faber
Northbrook, Trustee of the 3rd District
Robert T. Fox
Chicago, Trustee of the 3rd District
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Princeton, Trustee of the 2nd District
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Lincoln, Trustee of the 5th District
Eugene Hoban
Chicago, Trustee of the 3rd District
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Gibson City, Trustee of the 11th District
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Casey, Trustee of the 8th District
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A. Edward Livingston
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Springfield, Trustee of the 5th District
Joseph R. O'Donnell
Glen Ellyn, Trustee of the 11th District
Mather Pfeiffenberger
Alton, Trustee of the 6th District
Ralph N. Redmond
Sterling, Trustee of the 2nd District
Jacob E. Reisch
Springfield, Trustee of the 5th District
George Shropshear
Chicago, Trustee of the 3rd District
Darrell H. Trumpe
Springfield, Trustee of the 5th District
Frederick E. Weiss
Harvey, Trustee of the 3rd District
Charles K. Wells
Mt. Vernon, Trustee of the 9th District
Fred Z. White
Chillicothe, Trustee of the 4th District
Cyril C. Wiggishoff
Chicago, Trustee of the 3rd District
Herman Wing
Chicago, Trustee of the 3rd District
Warren W. Young
Chicago, Trustee of the 3rd District
Paul P. Youngberg
Moline, Trustee of the 4th District



Trustee Districts

TRUSTEE DISTRICT COMMITTEES

First District

John J. Ring, Mundelein, *Trustee*
Counties of Kane, Lake, McHenry

Ethical Relations Committee	Term Expires
David Clark, Aurora, *Chairman*	1984
Emanuel Herzon, Elgin	1984
Gerald Liesen, St. Charles	1982
A. M. Rosetti, McHenry	1983

Peer Review Committee	
David Helberg, Waukegan, *Chairman*	1984
Eugene Pitts, Waukegan	1984
James Pritchard, Geneva	1984
Peter Vinceguerra, Libertyville	1984

Second District

Allan L. Goslin, Streator, *Trustee*
Counties of Bureau, LaSalle, Livingston, Marshall, Putnam, Woodford

Ethical Relations Committee	Term Expires
William Erkonen, Streator, *Chairman*	1983
Julius Kowalski, Princeton	1983
Karl T. Deterding, Pontiac	1983
Merle Swearingen, Lacon	1983

Peer Review Committee	
Louis Tarsinos, Princeton, *Chairman*	1982
James B. Aplington, LaSalle	1982
Silvio Davito, Spring Valley	1982
Bernard J. Doyle, LaSalle	1982
William Ehling, Streator	1983
Rowland Musick, Mendota	1982
Theodore W. Wagenknecht, Streator	1982
Robert Betasso, Ottawa	1982

Third District

Alfred Clementi, Arlington Heights, *Trustee*
Audley F. Connor, Jr., Chicago, *Trustee*
Jere Freidheim, Chicago, *Trustee*
Morris T. Friedell, Chicago, *Trustee*
Robert C. Hamilton, Chicago, *Trustee*
Henrietta Herbolsheimer, Chicago, *Trustee*
Lawrence L. Hirsch, Chicago, *Trustee*
Harold J. Lasky, Chicago, *Trustee*
Richard N. Rovner, Chicago, *Trustee*
Joseph C. Sherrick, Chicago, *Trustee*

Fourth District

George Burke, Rock Island, *Trustee*
Counties of Fulton, Hancock, Henderson, Henry, Knox, McDonough, Mercer, Peoria, Rock Island, Schuyler, Stark, Tazewell, Warren

Ethical Relations Committee	Term Expires
Richard Icenogle, Roseville, *Chairman*	1983
Earl Clark, Rock Island	1984
Jerry Ramunis, Victoria	1982

Peer Review Committee	
Donald Dexter, Macomb, *Chairman*	1983
William Daugherty, Moline	1984
G. W. Giebelhausen, Peoria	1984
James C. Parsons, Geneseo	1982
Clarence Ward, Peoria	1984
Richard Flacco, Galesburg	1982

Fifth District

Robert Prentice, Springfield, *Trustee*
Counties of DeWitt, Logan, McLean, Mason, Menard, Montgomery, Sangamon

Ethical Relations Committee	Term Expires
Richard H. Suhs, Springfield, *Chairman*	1983
Jack Means, Mason City	1984
A. L. Van Ness, Bloomington	1982

Peer Review Committee	
James Borgerson, Mt. Pulaski, *Chairman*	1983
George Irwin, Bloomington	1982
Paul Lafata, Springfield	1983
Robert B. Perry, Lincoln	1982
Donald Yurdin, Springfield	1982
Clifford Draper, Hillsboro	1982
Albert Cunningham, Normal	1983

Sixth District

Robert R. Hartman, Jacksonville, *Trustee*
Counties of Adams, Brown, Calhoun, Cass, Green, Jersey, Macoupin, Madison, Morgan, Pike, Scott

Ethical Relations Committee	Term Expires
Newton DuPuy, Quincy, *Chairman*	1983
Bernard Baalman, Hardin	1984
Edward K. DuVivier, Alton	1983
C. B. Lara, Pittsfield	1984
Robert Roy, Jacksonville	1984

Peer Review Committee	
Walter Stevenson III, Quincy, *Chairman*	1983
E. C. Bone, Jacksonville	1982
Robert England, Carlinville	1984
Robert C. Murphy, Quincy	1982
Edward Ragsdale, Alton	1983
James Sutherland, Quincy	1983
Robert F. Hamliton, Alton	1984

Seventh District

Alfred J. Kiessel, Decatur, *Trustee*
Counties of Bond, Christian, Clay, Clinton, Effingham, Fayette, Macon, Marion, Moultrie, Piatt, Shelby

Ethical Relations Committee	Term Expires
H. Gale Zacheis, Decatur, *Chairman*	1982
P. D. L. Nayak, Effingham	1984
E. F. Stephens, III, Centralia	1982
I. Del Valle, Taylorville	1982

Peer Review Committee	
M. K. Kaufman, Greenville, *Chairman*	1983
H. Gale Zacheis, Decatur	1983
Clarence G. Glenn, Decatur	1982
D. H. Rames, Vandalia	1982

Eighth District

James Laidlaw, Champaign, *Trustee*
Counties of Champaign, Clark, Coles, Crawford, Cumberland, Douglas, Edgar, Jasper, Lawrence, Richland, Vermilion

Ethical Relations Committee	Term Expires
Mack W. Hollowell, Charleston, *Chairman*	1983
James H. Pass, Olney	1984
R. R. Manson, Urbana	1982
Stanley R. Huffman, Charleston	1983

Peer Review Committee	
George T. Mitchell, Marshall, *Chairman*	1984
E. T. Baumgart, Danville	1983
Gordon Sprague, Paris	1982
R. C. Adams, Champaign	1982

Ninth District

Warren D. Tuttle, Harrisburg, *Trustee*
Counties of Alexander, Edwards, Franklin, Gallatin, Hamilton, Hardin, Jackson, Jefferson, Johnson, Massac, Pope, Pulaski, Saline, Union, Wabash, Wayne, White, Williamson

Ethical Relations Committee	Term Expires
Alex Goldstein, Harrisburg, *Chairman*	1982
Eli Borkon, Carbondale	1983
Robert Rader, Anna	1983

Peer Review Committee	
C. J. Jannings, III, Fairfield, *Chairman*	1982
Philip D. Boren, Carmi	1983
Larry Jones, Harrisburg	1984
Roger Klam, Carbondale	1984
Harry L. Lewis, Benton	1982
Charles K. Wells, Mt. Vernon	1982

Tenth District

Thomas P. Meirink, Belleville, *Trustee*
Counties of Monroe, Perry, Randolph, St. Clair, Washington

Ethical Relations Committee	Term Expires
H. P. Dexheimer, Belleville, *Chairman*	1982
Roy Kenney, E. St. Louis	1982
Edilberto Maglasang, Columbia	1982
Wm. A. Simmons, Belleville	1982

Peer Review Committee	
William H. Walton, Lenzburg, *Chairman*	1984
Benjamin Arenas, Belleville	1982
Ted Bryan, Belleville	1982
R. W. Jost, Waterloo	1984
R. E. Schettler, Red Bud	1983
Ron Welch, Belleville	1984

Eleventh District

Kenneth Hurst, Naperville, *Trustee*
Counties of DuPage, Ford, Grundy, Iroquois, Kankakee, Kendall, Will

Ethical Relations Committee	Term Expires
James Ryan, Kankakee, *Chairman*	1981
Lawrence D. Lee, Manhattan	1982
Merle Otto, Frankfort	1982
William C. Perkins, West Chicago	1982

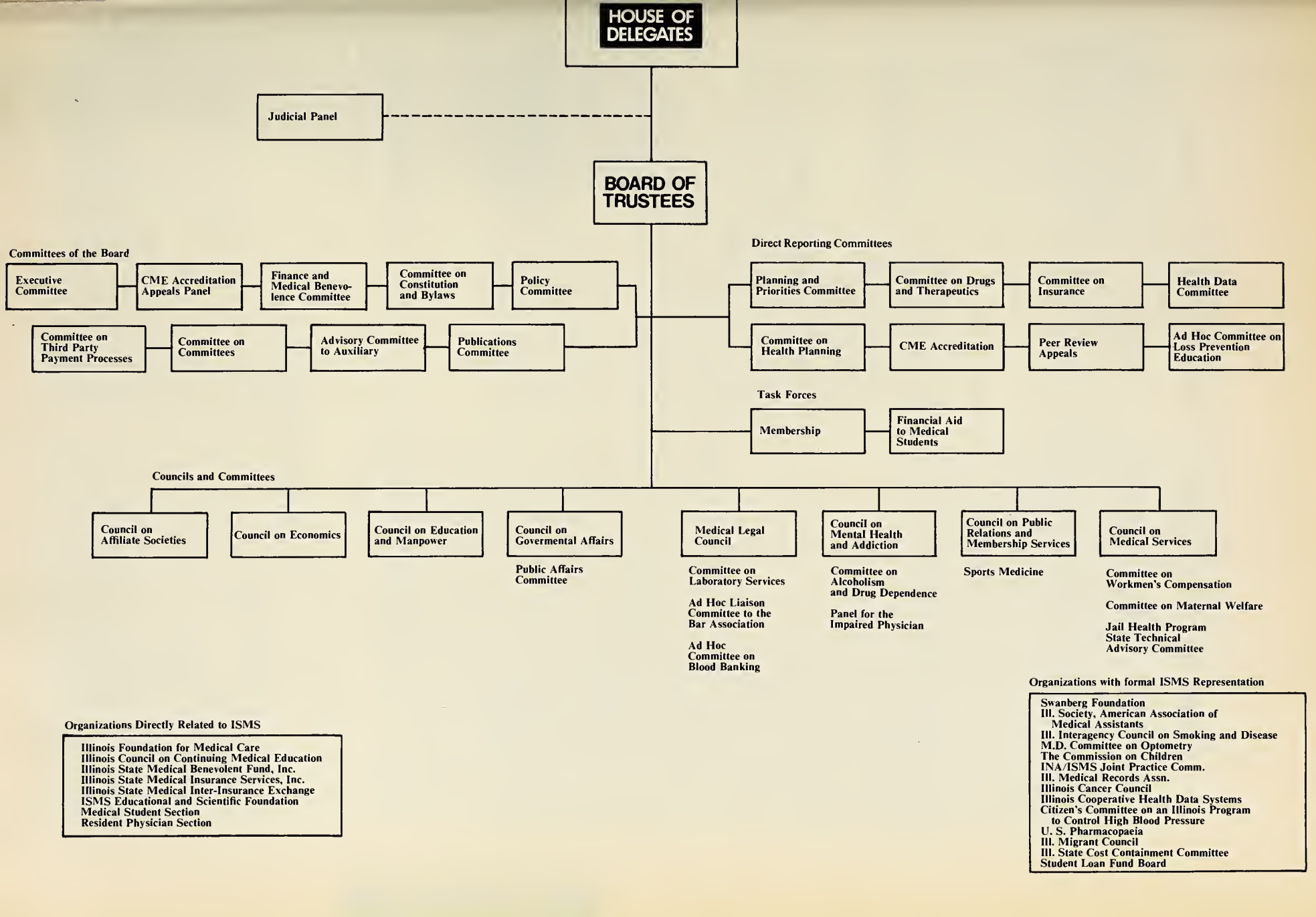
Peer Review Committee	
James Campbell, Wheaton, *Chairman*	1984
James E. Dailey, Watseka	1984
Guy Pandola, Joliet	1984
A. G. Parkhurst, Kankakee	1983
W. H. Brill, Oswego	1983
Charles G. White, Naperville	1982
Alex Spadoni, Joliet	1982

Twelfth District

Joseph Perez, Rockford, *Trustee*
Counties of Boone, Carroll, DeKalb, Jo Daviess, Lee, Ogle, Stephenson, Whiteside, Winnebago

Ethical Relations Committee	Term Expires
P. John Seward, Rockford, *Chairman*	1983
John H. Steinkamp, Belvidere	1984
Frank Luedke, DeKalb	1984
Frank Descourouez, Freeport	1982

Peer Review Committee	
P. John Seward, Rockford, *Chairman*	1983
Frank Luedke, DeKalb	1984
John H. Steinkamp, Belvidere	1984
Frank Descourouez, Freeport	1982



Organizations Directly Related to ISMS

- Illinois Foundation for Medical Care
- Illinois Council on Continuing Medical Education
- Illinois State Medical Benevolent Fund, Inc.
- Illinois State Medical Insurance Services, Inc.
- Illinois State Medical Inter-Insurance Exchange
- ISMS Educational and Scientific Foundation
- Medical Student Section
- Resident Physician Section

Organizations with formal ISMS Representation

- Swanberg Foundation
- Ill. Society, American Association of Medical Assistants
- Ill. Interagency Council on Smoking and Disease
- M.D. Committee on Optometry
- The Commission on Children
- INA/ISMS Joint Practice Comm.
- Ill. Medical Records Assn.
- Illinois Cancer Council
- Illinois Cooperative Health Data Systems
- Citizen's Committee on an Illinois Program to Control High Blood Pressure
- U. S. Pharmacopaeia
- Ill. Migrant Council
- Ill. State Cost Containment Committee
- Student Loan Fund Board

Councils of the Illinois State Medical Society

Councils of the Illinois State Medical Society are appointed by the Chairman of the Board of Trustees subject to approval of the Board of Trustees. The councils are composed of such members as are necessary to accomplish the purposes of the council. Some committees are composed of members of the Board of Trustees and are designated Board Committees. Some free standing committees may report directly to the board and may not be assigned to a council. Task Forces are established to address a particular problem or concern which crosses areas of responsibility of the several councils. The task forces report directly to the board, as do representatives to various other agencies. The President, Speaker of the House, and Chairman of the Board are, by virtue of their office, *ex-officio* members of all groups.

COUNCIL ON AFFILIATE SOCIETIES

Robert C. Muehrcke, Oak Park, *Chairman*
Ill. Chapter, American College of Physicians
Jerome S. Beigler, Chicago
Ill. Psychiatric Society
Robert Borkenhagen, Indian Head Park
Chicago Laryngological & Otological Society
Raymond A. DelFava, Evanston
Ill. Radiological Society
Raymond A. Dieter, Jr., Glen Ellyn
Ill. Thoracic Surgical Society
John M. Dietrich, Springfield
Ill. Society of Pathology
Richard E. Dukes, Urbana
Ill. Chapter, American Academy of Pediatrics
Malachi Flanagan, Chicago
Chicago Urological Society
Anthony Finder, Chicago
Ill. Association of Ophthalmology, Inc.
Gustav Giebelhausen, Peoria
Ill. Chapter, American College of Surgeons
Donald H. Hanscom, Hinsdale
Ill. Society of Internal Medicine
Donald R. Ingram, Godfrey
Ill. Society of Ophthalmology and Otolaryngology
Robert Johnson, Springfield
Ill. Section, American College of OB-GYN
William J. Kane, Chicago
Ill. Orthopaedic Society
M. Barry Kirschenbaum, Chicago
Ill. Dermatological Society
David H. Paul, Belleville
Ill. Chapter, American College of Emergency Physicians
Ronald P. Pawl, Chicago
Ill. Neurosurgical Society
J. Roger Powell, Urbana
Ill. OB-GYN Society
Donald P. Schwartz, Flossmoor
Allergy and Clinical Immunology Society of Ill.
Robert Swastek, Chicago
Ill. Chapter, American Academy of Family Physicians
Bernard V. Wetchler, Peoria
Ill. Society of Anesthesiologists

OTHER ORGANIZATIONS REPRESENTED:
Illinois Surgical Society

CONSULTANT:
Cyril Wiggishoff, Chicago

Responsibilities and Purposes:

To improve communication and provide liaison with the specialty societies; provide specialty consultation to other ISMS councils and committees; and to serve as a resource unit to ISMS on advances in the medical specialties.

COUNCIL ON ECONOMICS

Ronald G. Welch, Belleville, *Chairman*
Lorris M. Bowers, Peoria
James R. DeBord, Peoria
Bernard J. Feldman, Chicago
Theodore Grevas, Rock Island
A. Beaumont Johnson, Elgin
Joseph M. Purpura, Winnetka
David Shapiro, Libertyville
Harry Springer, Winnetka

CONSULTANTS:
Allan L. Goslin, Streator
Alfred J. Kiessel, Decatur

STUDENT
Joseph M. Hughes, Chicago

RESIDENT
David Whitney, Chicago

Responsibilities and Purposes:

The Council on Economics maintains ongoing dialogue with third party payors and considers issues regarding the costs and utilization of health care services. The council is interested in effective practice management and the economic impact of both government health policies and new health care delivery systems.

COUNCIL ON EDUCATION AND MANPOWER

Boyd McCracken, Sr., Greenville, *Chairman*
Randall Bellows, Chicago
David Bristow, Effingham
Earl Fredrick, Olympia Fields
Mack Hollowell, Charleston
Ronald Johnson, Pleasant Hill
Eugene B. Loftin, Fairfield
Albert Maurer, Hopedale
Roger A. Nosal, Chicago
Aldo F. Pedroso, Skokie
Pedro A. Poma, Melrose Park
Simon Zivin, Chicago

RESIDENT REPRESENTATIVE
John Diveris, Chicago

STUDENT REPRESENTATIVE
Jere Hines, Chicago

CONSULTANTS:
Lawrence L. Hirsch, Chicago
Robert P. Johnson, Springfield

Responsibilities and Purposes:

The Council on Education and Manpower shall study and evaluate all phases of medical education, including the development of programs by and for ISMS, and review programs for allied health personnel. It shall carry to the deans of medical schools recommendations from the viewpoint of the practicing physician. It shall evaluate available postgraduate programs, advise the Illinois Dept. of R&E, and review hospital oriented education programs. Liaison shall be maintained with medical students and physicians-in-training and with loan programs for medical students. Activities regarding physician distribution and retention shall also be within the scope of the Council, as well as medical licensure as it relates to education.

GOVERNMENTAL AFFAIRS COUNCIL

P. John Seward, Rockford, *Chairman*
Harlan Failor, Urbana
Edward G. Ference, Springfield
William D. Fish, Chicago
David S. Fox, Chicago
Jerome Frankel, Evanston
Henri Havdala, Chicago
Don Hinderliter, Rochelle
John R. Lumpkin, Chicago
Paul Mahon, Springfield
George T. Mitchell, Marshall
Jerry Ramunis, Galesburg
Herbert Sohn, Chicago
Alex Spadoni, Joliet
Arthur Traugott, Urbana

AUXILIARY REPRESENTATIVE
Mrs. Alan Taylor, Danville

STUDENT REPRESENTATIVE
Edgar Staren, Burr Ridge

CONSULTANTS:
Robert R. Hartman, Jacksonville
James M. Laidlaw, Champaign

ILLINOIS MEDICAL GROUP MANAGEMENT ASSOCIATION REPRESENTATIVE
Nancy Koch, Chicago

Responsibilities and Purposes:

1. Keep the Society and its members aware of all state and federal legislation and laws affecting the health of citizens of Illinois and the practice of medicine in Illinois.
2. Promulgate legislation to improve the health care of citizens of Illinois and the practice of medicine in Illinois.
3. Co-operate with the AMA in similar programs.
4. Develop programs to educate the public and the Illinois State Medical Society membership in the privileges and responsibilities of citizenship.

Committees:

Public Affairs

PUBLIC AFFAIRS COMMITTEE

Herbert Sohn, Chicago, *Chairman*
James H. Andersen, Oak Brook
Eugene Branovacki, Chicago
Robert Chapman, Normal
Louis Dondanville, Moline
Sandra J. Olson, Chicago
Edward Ragsdale, Alton
Albert W. Ray, Jr., Joliet
Willard C. Scrivner, Belleville
A. E. Steer, Springfield
Ronald E. Sumner, Dunlap
Mrs. Alan Taylor, Danville
George Wilkins, Edwardsville

CONSULTANT:
Theodore Grevas, Rock Island

Responsibilities and Purposes:

The Public Affairs Committee is responsible for educating physicians about the political process and encouraging political involvement. The Committee also provides educational material on issues of interest to physicians and promotes physician involvement in public affairs activity.

MEDICAL LEGAL COUNCIL

Donald Aaronson, Chicago, *Chairman*
Nelson Borelli, Wilmette
Saul Haskell, Chicago
Herbert Henkel, Springfield
B. Jay Hill, Glen Ellyn
Morgan Meyer, Lombard
Michael Murphy, Belleville
Lawrence K. Richards, Urbana
Sam Sugar, Evanston
Robert Sumner, Harrisburg
J. Robert Thompson, Oak Park (*Lab. Services)*
Michael Victor, Buffalo Grove

CONSULTANTS:

James Laidlaw, Champaign
Kenneth Hurst, Naperville

RESIDENT REPRESENTATIVE

Robert Eilers, Evanston

STUDENT REPRESENTATIVE

James Kelly, Chicago

Responsibilities and Purposes:

The Medical Legal Council shall cooperate with all organizations interested in medico-legal problems in order to educate members of the profession in medico-legal affairs.

This council shall maintain liaison with the Illinois Bar Association and cooperate with the judiciary in both federal and state courts within the state of Illinois. It shall, when requested by the court, activate the Impartial Medical Testimony panel. The stated objective of the panel is to provide consultations, judgment and opinions in situations in which there is unusual controversy or wide divergence of medical opinion.

The council shall study recommendations for methods of elevating and maintaining the standards of medical laboratories in Illinois. In addition, the council shall be concerned with standards of practice, licensure and quackery.

Committees:

Impartial Medical Testimony
Laboratory Services
Ad Hoc Statewide Bloodbanking Coordinating Committee

COMMITTEE ON LABORATORY SERVICES

J. Robert Thompson, Oak Park, *Chairman*
Newell Braatelein, Moline
John Dietrich, Springfield
John Mason, Oak Lawn
Richard Sassetti, Chicago
Marshall Short, Chicago
Peter Soto, Belleville
Earl Suckow, Mt. Prospect
Benjamin Williams, Urbana

CONSULTANT:

Alfred J. Kiessel, Decatur

Responsibilities and Purposes:

The Committee shall monitor methods of elevating and maintaining the standards of medical laboratories in Illinois, encourage the use of medical diagnostic laboratories supervised by duly qualified physicians and encourage each county and district to establish evaluation committees. It will cooperate with various state agencies in promoting a safe, adequate blood supply for the state.

COUNCIL ON MENTAL HEALTH AND ADDICTION

Jerome Beigler, Chicago, *Chairman*
Douglas R. Bey, Normal
George Borge, Berwyn
Leroy Levitt, Chicago
S. Dale Loomis, Chicago *(IPS Liaison)*
Kermit Mehlinger, Chicago
Edward Senay, Chicago
(Comm. on Alcoholism & Drug Dependence)
Mark Sinabaldi, Joliet
Garth Smith, Hinsdale
Robert Study, Chicago
Kishore Thampy, Chicago
Arthur Woloshin, Highland Park

CONSULTANT:

Richard Rovner, Chicago

AUXILIARY REPRESENTATIVE

Mrs. Alex Spadoni, Hinsdale

STUDENT REPRESENTATIVE

Frank J. Pieri, Berwyn

IDMHDD REPRESENTATIVE:

John Nelson, Elgin

Responsibilities and Purposes:

This council shall serve as a source of information on mental health matters for ISMS, evaluate information and make recommendations to the Board of Trustees on positions ISMS should take on issues in this area, and cooperate with institutions, voluntary health agencies, state agencies and professional associations in disseminating information on mental health, alcoholism and drug abuse.

The council shall be on the alert for misleading or fallacious programs and information, and recommend appropriate action. It shall also be concerned with reviewing legislation and regulations related to the fields of mental health, alcoholism, drug abuse, and hazardous substances.

Committee:

Alcoholism and Drug Dependence

COMMITTEE ON ALCOHOLISM AND DRUG DEPENDENCE

Edward C. Senay, Chicago, *Chairman*
Richard Banta, Rockford
Vincent Costanzo, Chicago
Lee Gladstone, Chicago
Donald Sellers, Des Plaines
James West, Evergreen Park

CONSULTANTS:
Linda Hargnett, DDC, Chicago
J. Roalda Alderman, Div. of Alcoholism, Chicago

Responsibilities and Purposes:

The Committee shall work closely with public and private agencies on projects aimed at eliminating the misuse of alcohol and drugs. The committee's functions include: (1) study, research and disseminate educational information on drugs and alcohol to members of the medical profession; (2) cooperate in the dissemination of information on the causes, prevention, diagnosis and treatment of alcoholism and drug dependence to the medical profession and to the public; (3) recommend acceptable measures for control of distribution and disposal of drugs and hazardous substances, exclusive of radiation products; and (4) cooperate with official and non-official agencies in all matters pertaining to this subject.

In April, 1977, ISMS established the Panel for the Impaired Physician. The Panel, which reports to the Committee on Alcoholism and Drug Dependence, consists of physicians who treat fellow physicians for problems related to alcohol or drug dependence, as well as impairment due to physical disabilities, mental or emotional disturbances.

COUNCIL ON PUBLIC RELATIONS AND MEMBERSHIP SERVICES

Peter Vinciguerra, Libertyville, *Chairman*
James Bauer, Peoria
Albino Bismonte, Gurnee
H. Bates Noble, Chicago
Reuben Ramkissoon, Hinsdale
Leo Wrona, Joliet

CONSULTANT:
Maynard Shapiro, Chicago

RESIDENT REPRESENTATIVE
Ken Kraudel, Springfield

STUDENT REPRESENTATIVE
John Dolehide, Hinsdale

AUXILIARY REPRESENTATIVE
Mrs. Gamil Arida, Joliet

Responsibilities and Purposes:

The Council on Public Relations and Membership Services shall plan and execute programs designed to enhance the relationship between the media, clergy, general public and medical profession. Included shall be health education and socio-economic programs believed to be in the best interest of the profession as well as the general public. The council shall be responsible for new member orientation, exhibits and public service programming.

Committees:
Sports Medicine

SPORTS MEDICINE COMMITTEE

H. Bates Noble, Chicago, *Chairman*
Bernie Cahill, Peoria
Henry Dold, Arlington Heights
Clarence Fossier, Lake Forest
James L. Green, Jacksonville
Ed Grogg, Urbana
Joseph Hinkamp, Glenview
J. M. Ingalls, Paris
Jacob Suker, Chicago
Howard J. Sweeney, Evanston

CONSULTANTS:
Audley Connor, Jr., Chicago
Robert C. Hamilton, Chicago

Responsibilities and Purposes:

To conduct programs aimed at improving the recognition and treatment of athletic-related injury and disease; provide educational material to junior and senior high school coaches and trainers; and work with other groups and organizations involved in sports medicine activities.

COUNCIL ON MEDICAL SERVICES

Joan Cummings, Hines, *Chairman*
Wallace P. Berkowitz, Belleville
C. Larkin Flanagan, Chicago
A. Everett Joslyn, River Forest
David B. Littman, Highland Park
John T. McEnery, Oak Park
Daniel J. Pachman, Chicago
Eugene J. Rogers, Chicago
Roy C. Selby, Lombard
Robert C. Stepto, Chicago
Joseph D. Winterhalter, Jacksonville

CONSULTANTS:
Allan L. Goslin, Streator
Maynard Shapiro, Chicago

AUXILIARY REPRESENTATIVE
Mrs. Selig Hodes, Forreston

STUDENT REPRESENTATIVE
John T. Ellena, Carbondale

RESIDENT REPRESENTATIVE
Lori Anderson, Oak Park

Responsibilities and Purposes:

The Council considers a broad range of issues and programs related to medical facilities, professional health education, public health, and services for the disadvantaged. Specific interest areas include nutrition, hospital-medical staff relations, emergency medical services, maternal and child welfare, workmen's compensation, and the penal health care services.

Committees:

Maternal Welfare
Committee on Workmen's Compensation
Illinois Jail Health Program—State Technical Advisory Committee

COMMITTEE ON MATERNAL WELFARE

DISTRICT MEMBERS AND ALTERNATES
(alternates in italics)

Robert C. Stepto, *Chairman*
1. Theodore London, Aurora
F. John Struwe, Lake Forest
2. Carl P. Mattioda, Streator
Ruthachai Rithaporn, Princeton
3. Robert C. Stepto, Chicago
Warren H. Staley, Chicago
4. Raoul E. Reinertsen, Canton
Charles C. Egley, Peoria
5. William H. Schultz, Springfield
Kofi S. Amankwah, Springfield
6. Richmond H. Simmons, Jacksonville
Richard D. Yoder, Alton
7. Herbert W. Thompson, Decatur
William L. Wagner, Decatur
8. Lewis Trupin, Champaign
Larry R. Lane, Champaign
9. Urduja Pulido, Murphysboro
Roger N. Klam, Carbondale
10. Stephen V. Mueller, Belleville
Casimiro Garcia, Jr., Belleville
11. Salvatore Reda, Wheaton
Kenneth M. Uznanski, Joliet
12. John F. Hubbard, Sterling
Gordon T. Burns, Rockford

CONSULTANTS:
Robert R. Hartman, Jacksonville
John Lewis, Lake Forest
Augusta Webster, Chicago

Responsibilities and Purposes:

The primary responsibility of this committee is to review cases of maternal mortality in Illinois. This function is performed under a contract with the state health department. The Committee also deals with issues involving maternal health services and perinatal care.

COMMITTEE ON WORKMEN'S COMPENSATION

Eugene J. Rogers, Chicago, *Chairman*
Ernest Adams, Peoria
Milton R. Carlson, Champaign
Harry C. Coblens, Chicago
Forrest H. Riordan, III, Rockford
Joseph Schiff, Chicago
Michael R. Treister, Chicago

CONSULTANT:
Henrietta Herbolsheimer

Responsibilities and Purposes:

The committee reviews how physicians are involved and affected by the Workmen's Compensation system in Illinois.

STATE TECHNICAL ADVISORY COMMITTEE ILLINOIS JAIL HEALTH PROGRAM, 1980-1981

Robert J. Kramer, Joliet, *Chairman*
Hon. Thomas P. Durkin, Ill. State Bar Association
Cyril L. Friend, Jr., DDS, Ill. State Dental Society
Marie Hall, Ill. Department of Corrections
Sheriff George Kramer, Ill. Sheriffs' Association
David B. Littman, Highland Park
Loretta Lynn, R.N., Ill. Nurses Assoc.
Mary Lou Pflum, Div. of Ambulatory Care, IDPH
Joseph D. Winterhalter, Jacksonville
Margaret Wright, R.S.M., Illinois Pharmacists Association

Responsibilities and Purposes:

The STAC provides overall direction to the Illinois Jail Health Program and assists jails in adapting their health systems to meet national and state standards for medical care.

Committees of the Board of Trustees

ADVISORY COMMITTEE TO ISMS AUXILIARY

Herschel Browns, Chicago, *Chairman*
Morris T. Friedell, Chicago
Fred Z. White, Chillicothe

Responsibilities and Purposes:

The committee shall consist of the immediate past president as chairman, the president, and the chairman of the Board. The committee shall provide advice and assistance to the president of the ISMS Auxiliary in her program for the year, and shall assist her in interpreting the activities of the state medical society to the auxiliary members.

CME ACCREDITATION APPEALS PANEL

George H. Burke, Rock Island
Jere E. Freidheim, Chicago
Henrietta Herbolsheimer, Chicago
John J. Ring, Mundelein
Joseph C. Sherrick, Chicago
Cyril C. Wiggishoff, Chicago

Responsibilities and Purposes:

When a Continuing Medical Education Sponsor appeals a Reconsideration decision of the Accreditation Committee, three members of this Panel will be selected to serve on a Hearing Committee, choosing names in rotation by alphabetic order. The member whose name is earliest in the alphabet will be designated Chair.

COMMITTEE ON COMMITTEES

Clifton L. Reeder, Wilmette, *Chairman*
Julian Buser, Belleville
Lawrence L. Hirsch, Chicago
Maynard I. Shapiro, Chicago
Warren D. Tuttle, Harrisburg

Responsibilities and Purposes:

The Committee on Committees shall consist of three members of the Board appointed by the chairman. It shall serve to review the purposes, activities and structure of any councils or committees at the request of the Board.

The committee shall recommend such changes in existing councils or committees as required to maintain the efficient operation of the affairs of the Society.

The activities and reports of the Committee on Committees shall be reviewed by the Executive Committee and approved by the Board of Trustees.

COMMITTEE ON CONSTITUTION AND BYLAWS

Lawrence L. Hirsch, Chicago, *Chairman*
Robert C. Hamilton, Chicago
Robert P. Johnson, Springfield
James Laidlaw, Champaign
Clifton L. Reeder, Wilmette

Responsibilities and Purposes:

The Committee on Constitution & Bylaws shall:

1) Receive from individual members, county societies, committees, the Board of Trustees and the House of Delegates, all suggestions and proposals for modification of the Constitution & Bylaws;

2) Prepare for the consideration of the House of Delegates, all changes in the Constitution & Bylaws; and

3) Maintain constant surveillance of both documents to keep them current, effective and consistent with the policies of the House of Delegates.

EXECUTIVE COMMITTEE

Morris Friedell, Chicago, *Chairman*
Herschel Browns, Chicago
Jere Freidheim, Chicago
Robert Hartman, Jacksonville
Eugene Johnson, Casey
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago

By Invitation (without vote)
Clifton Reeder, Chicago

Ex Officio (without vote)
Theodore Grevas, Rock Island

Responsibilities and Purposes:

The Executive Committee shall consist of the president, the president-elect, the first vice president, the chairman of the Board, the chairman of the Finance and Medical Benevolence Committee, the secretary-treasurer and the trustee-at-large. The immediate past chairman of the Board shall be a member, provided he is still a Trustee. If the immediate past chairman is no longer a Trustee, the chairman of the Policy Committee shall serve on the Executive Committee.

The chairman of the Illinois Delegation to the American Medical Association, or the secretary in his absence, shall serve as an ex-officio member of the Executive Committee without vote.

It may be given authority to act by the Board of Trustees.

In matters of routine administration, special plans, policy, endorsement or expenditure it shall report to and request approval of the Board. It shall receive the reports of the Finance and Policy Committees and make recommendations concerning them to the Board. It shall furnish a report of its actions to the Board at each meeting.

(Bylaws, Chapter IX, Part 4, Section 2, Paragraph A.)

FINANCE COMMITTEE AND MEDICAL BENEVOLENCE

Jere E. Freidheim, Chicago, *Chairman*
Audley F. Connor, Jr., Chicago
Eugene P. Johnson, Casey
Joseph Perez, Rockford

Auxiliary Representative
Mrs. Louis Tarsinos

Responsibilities and Purposes:

The Committee shall consist of the secretary-treasurer of the Society and three members of the Board appointed by the chairman. It shall develop a budget for the fiscal year for approval of the Board through the Executive Committee. It shall supervise the financial transactions of the Society. It shall make recommendations to the Board for the control and investment of the funds of the Illinois State Medical Society.

The Finance Committee shall also be responsible for the society's Medical Benevolence Program and shall:

1. Examine applications for financial assistance and determine eligibility.
2. Keep the names of the beneficiaries confidential and known only to the committee.
3. Determine the allotment for each recipient.
4. If funds available become inadequate to meet disbursements, request the Board of Trustees to appropriate sufficient funds to support the program until the next budget appropriation.

POLICY COMMITTEE

Affred Kiessel, Decatur, *Chairman*
George Burke, Rock Island
Harold J. Lasky, Chicago

Responsibilities and Purposes:

The Policy Committee shall consist of three members of the Board appointed by the chairman. It shall annually review all policy statements adopted five or more years previously and incorporate suggestions for revisions and deletions into resolutions for approval by the Board of Trustees and introduction in the House of Delegates. It shall also make recommendations for future policy by Board resolution to the House.

PUBLICATIONS COMMITTEE

Joseph Sherrick, Chicago, *Chairman*
Henrietta Herbolsheimer, Chicago
Kenneth Hurst, Naperville
Robert Prentice, Springfield
John J. Ring, Mundelein

Responsibilities and Purposes:

The Publications Committee shall be composed of five members of the Board of Trustees, and shall be responsible for the production of the *Illinois Medical Journal* and other Society publications.

It shall recommend to the Board of Trustees all policies governing the editorial, business and production aspects of the *Journal.* It shall supervise the editorial board in the selection and preparation of all copy, and it shall establish standards for the editorial content.

It shall establish advertising policies, rates and standards, and shall review all new accounts prior to acceptance, and shall approve reprint and circulation policies.

It shall conduct a periodic review of the printer's contract and solicit bids as indicated. It shall establish the format, cover, type faces and general layout of the *Journal.*

The committee may establish such editorial consultation groups as necessary to assist in development of clinical articles and shall authorize all regular and special features.

IMJ Editorial Board

J. William Roddick, Jr., Springfield, *Chairman*
Eli L. Borkon, Carbondale
Eugene J. Rogers, Chicago
Raymond A. Dieter, Jr., Glen Ellyn
James G. Ekeberg, Palatine
Ediz Z. Ezdinli, Kenilworth
Carl Neuhoff, Peoria
Constantine S. Soter, Northbrook
Donald D. VanFossan, Springfield

THIRD PARTY PAYMENT PROCESSES COMMITTEE

Audley F. Connor, Jr., Chicago, *Chairman*
Alfred J. Clementi, Arlington Heights
Allan L. Goslin, Streator
Robert P. Johnson, Springfield
Thomas P. Meirink, Belleville
Maynard I. Shapiro, Chicago
Cyril C. Wiggishoff, Chicago

ILL. MEDICAL GROUP MNGMT. ASSOC. REPS.
Sherwin Sern, Crystal Lake
Mary M. Yarbrough, Chicago

CONSULTANT:
Arthur R. Traugott, Urbana
Illinois Psychiatric Society

Responsibilities and Purposes:

The Third Party Payment Processes Committee is a negotiating committee which deals with matters related to governmental health care reimbursement—i.e., Medicaid (IDPA), Medicare (EDS-F) and CHAMPUS (WPS). The committee deals with administration of these programs and oversees staff efforts aimed at resolving policy, payment and audit issues.

Direct Reporting Committees

All Board Committees previously noted consist of members of the Board of Trustees. As such they function within the activities of the Board.

Direct Reporting Committees are groups deemed necessary by the Board of Trustees and are created by the Board to meet specific challenges. These committees may function with, and under, a council, or may report directly to the Board of Trustees.

While other select committees may be formed from time to time, at the time of publication the following groups had been established.

COMMITTEE ON CME ACCREDITATION

Robert A. Behmer, Rockford, *Chairman*
James H. Geist, Kankakee
Terry F. Hatch, Urbana
Joseph P. McKay, Elmhurst
David M. Roxe, Chicago
Birendra K. Sinha, Elk Grove Village
Dennis J. Stanczyk, Belleville

CONSULTANT:
Maynard I. Shapiro, Chicago

Responsibilities and Purposes:

Adopt necessary procedural rules and prescribe forms to be used in the conduct of CME accreditation, within prescribed policies. Review Sponsor applications and Survey Team reports for intrastate CME Sponsors, and make decision on grant of initial accreditation and continuation of accredited status.

ILLINOIS CME SPONSORS ACCREDITED FOR CONTINUING MEDICAL EDUCATION AS OF OCTOBER 1, 1981

Alexian Brothers Medical Center—Elk Grove Village
Alfred Adler Institute of Chicago, Inc.
Augustana Hospital—Chicago
Belleville Hospital Association for CME
(Memorial Hospital, St. Elizabeth Hospital)
Carle Foundation Hospital—Urbana
Central Community Hospital—Chicago
Central DuPage Hospital—Winfield
Chicago College of Osteopathic Medicine
Chicago Medical Society
Chicago Pediatric Society
Christ Hospital—Oak Lawn
Columbus-Cuneo-Cabrini Medical Center—Chicago
Community Memorial General Hospital—LaGrange
Cook County Hospital—Chicago
Copley-Mercy CME Consortium—Aurora
DuPage County Medical Society
Elgin Mental Health Center
FAB^3-CME, (Forkosh Memorial, Belmont Community, Bethesda, Bethany Methodist, Thorek Medical Center) Chicago
Forest Hospital—Des Plaines
Good Samaritan Hospital—Downers Grove
Gottlieb Memorial Hospital—Melrose Park
Grant Hospital of Chicago
Henry Horner Childrens' Center—Chicago
Highland Park Hospital
Hinsdale Sanitarium & Hospital
Holy Cross Hospital—Chicago
Illinois Central Community Hospital—Chicago
Illinois Council on Continuing Medical Education
Illinois Heart Association
Illinois Hospital Research & Educational Foundation-Illinois Hospital Association

Illinois Masonic Medical Center—Chicago
Illinois Society of Allergy and Clinical Immunology
Ingalls Memorial Hospital—Harvey
Institute for Psychoanalysis—Chicago
Jackson Park Hospital—Chicago
Lake Forest Hospital
Little Company of Mary Hospital—Evergreen Park
Loretto Hospital—Chicago
Louis A. Weiss Memorial Hospital—Chicago
Loyola University Stritch School of Medicine—Maywood
Lutheran Hospital—Moline
Lutheran General Hospital—Park Ridge
MacNeal Memorial Hospital—Berwyn
Martha Washington Hospital—Chicago
Mary Thompson Hospital—Chicago
Mazel Medical Center-Edgewater Hospital—Chicago
Memorial Hospital of DuPage County—Elmhurst
Mercy Hospital & Medical Center—Chicago
The Methodist Medical Center of Illinois—Peoria
Michael Reese Hospital & Medical Center—Chicago
Mount Sinai Hospital Medical Center of Chicago
Northwestern University Medical School—Chicago
North Shore Mental Health Association/Irene Josselyn Clinic—Northfield
Northwest Hospital—Chicago
Northwest Community Hospital—Arlington Heights
Norwegian-American Hospital—Chicago
Oak Forest Hospital
Oak Park Hospital
Provident Hospital—Chicago
Ravenswood Hospital Medical Center—Chicago
Resurrection Hospital—Chicago
Riveredge Hospital—Forest Park
Riverside Hospital—Kankakee
Rock Island Franciscan Medical Center
Rockford Memorial Hospital
Roosevelt Memorial Hospital—Chicago
Rush Medical College—Chicago
Sarah Bush Lincoln Health Center—Mattoon
Sherman Hospital—Elgin
Silver Cross Hospital—Joliet
Skokie Valley Community Hospital—Skokie
South Chicago Community Hospital
Southern Illinois Medical Association—Belleville
Southern Illinois University School of Medicine—Springfield
St. Anne's Hospital—Chicago
St. Anthony Hospital—Chicago
St. Anthony Hospital—Rockford
St. Elizabeth's Hospital—Chicago
St. Elizabeth Hospital—Danville
St. Francis Hospital—Blue Island
St. Francis Hospital-Medical Center—Peoria
St. Joseph Hospital—Chicago
St. Joseph Hospital—Elgin
St. Mary's Hospital—Kankakee
St. Mary's Hospital—Streator
St. Mary of Nazareth Hospital—Chicago
St. Theresa Hospital—Waukegan
Swedish American Hospital—Rockford
Swedish Covenant Hospital—Chicago
University of Chicago Pritzker School of Medicine
University of Health Sciences/The Chicago Medical School
University of Illinois College of Medicine
Victory Memorial Hospital—Waukegan
Westlake Community Hospital—Melrose Park
West Suburban Hospital—Oak Park
Woodlawn Hospital—Chicago
Wood River Township Hospital

COMMITTEE ON DRUGS AND THERAPEUTICS

Charles A. Beck, Chicago, *Chairman*
Andrew Brislen, Chicago
Amin N. Daghestani, Skokie
Ignacio DelValle, Taylorville
John Hyde, Oak Park
Dorothy Hubler, Casey

CONSULTANTS:
Vincent Costanzo, Jr., Chicago
Louis Gdalman,R.Ph., Oak Brook
Kerrison Juniper, Jr., Springfield

Responsibilities and Purposes:

The committee shall meet periodically to review the listing of pharmaceutical products in the IDPA Drug Manual. When it deems it necessary to list new products in the Manual, the committee shall request the Board of Trustees to approve and forward its recommendations to the Illinois Department of Public Aid. Special approval of drugs not listed in the Manual also falls under the purview of the committee and is reported to IDPA. Comments or suggestions made by the membership regarding drugs are reviewed by the committee.

HEALTH DATA COMMITTEE

Andrew Brislen, Chicago, *Chairman*
Audley F. Connor, Jr., Chicago
Alexander Goldstein, Harrisburg
Allan Goslin, Streator
Donald H. Hanscom, Hinsdale
Henrietta Herbolsheimer, Chicago
James Laidlaw, Champaign
Joseph R. O'Donnell, Glen Ellyn
Paul Peterson, Chicago
Clifton L. Reeder, Wilmette
Walter Stevenson, Quincy
Ben T. Williams, Urbana

CONSULTANT:
Alexander R. Lerner

Responsibilities and Purposes:

The committee shall maintain ongoing awareness of: (1) systems for the collection and dissemination of health care data, (2) government, 3rd party and other agency requirements for the reporting of health care data and (3) laws and government regulations pertaining to confidentiality. For committee purposes health care data includes but is not limited to: (1) hospital patient care statistics, (2) long-term care statistics, (3) ambulatory care statistics, (4) institutional financial data, (5) medical manpower, (6) vital statistics, and (7) information obtained from health care surveys.

The committee shall be knowledgeable of the workings of PSROs, HSAs, the Illinois Cooperative Health Data System (ICHDS), governmental agencies and others with respect to the collection and dissemination of health care data. To the extent feasible, the Committee shall provide informal liaison between the foregoing organizations and ISMS. The committee shall keep the officers, Board of Trustees and other appropriate persons within ISMS advised on data collection matters.

COMMITTEE ON HEALTH PLANNING

Samuel L. Andelman, Skokie, *Chairman*
Ronald F. Albrecht, Chicago
Eli L. Borkon, Carbondale
Angelo Creticos, Chicago
Robert D. Dooley, Oak Brook
Gerald W. Grawey, Peoria
M. Kenneth Kaufmann, Greenville
John S. Schweppe, Chicago
Robert C. Wanless, Belleville
Richard S. Webb, Rockford

CONSULTANTS:
Alfred J. Kiessel, Decatur
Joseph R. O'Donnell, Glen Ellyn
Maynard I. Shapiro, Chicago

Responsibilities and Purposes:

The Committee has responsibility for keeping physicians abreast of all developments in the area of health planning and encouraging a leadership role for physicians in this important field. The Committee maintains ongoing liaison with the State Planning Agency, the Statewide Health Coordinating Council, the Health Facilities Planning Board and the local areawide health planning agencies

COMMITTEE ON INSURANCE

Gerald S. Modjeska, Chicago, *Chairman*
Anne L. Barlow, N. Chicago
Philip Boren, Carmi
William Henry, Springfield

CONSULTANTS:
Alfred Clementi, Arlington Heights

Responsibilities and Purposes:

The Committee on Insurance monitors the ISMS-sponsored insurance programs for members. Current policies and new types of insurance programs are evaluated in order to recommend changes that may benefit society members. The Committee works closely with the programs' administrator, Corroon & Black, Inc.

AD HOC COMMITTEE ON LOSS PREVENTION EDUCATION

Alfred Clementi, Arlington Heights, *Chairman*
Donald Aaronson, Chicago
Phillip Boren, Carmi
Clinton Compere, Chicago
Robert R. Hartman, Jacksonville
Warren Tuttle, Harrisburg
Richard Wilbur, Lake Forest

Responsibilities and Purposes:

The ad hoc Committee on Loss Prevention Education seeks to help physicians identify legal dicta and court procedures and the application of these to medical practice. It seeks to enable physician identification of potential problems in various medical procedures and practice settings and effect a change in same. Educational efforts are intended to improve the quality of medical care and prevent law suits.

PEER REVIEW APPEALS COMMITTEE

George J. Gertz, Chicago, *Chairman*
Boonmee Chunprapaph, Hinsdale
Vincent C. Freda, Chicago
Eugene T. Hoban, Oak Park
Carl Johnson, Moline
Lloyd E. Thompson, East St. Louis
Charles Wells, Mt. Vernon

Responsibilities and Purposes:

This committee serves as the appellate body for cases appealed from local or district peer review committees. Peer review involves the medical review of cases concerning the utilization and quality of medical services, as well as patient relation issues. The committee is the State Society's liaison to local peer review committees and monitors review activities around the state.

PLANNING AND PRIORITIES COMMITTEE

Cyril C. Wiggishoff, Chicago, *Chairman*
Richard Blankshain, Oak Park
Lorris M. Bowers, Peoria
Alfred J. Clementi, Arlington Heights
Jere E. Freidheim, Chicago
Eugene P. Johnson, Casey
Robert P. Johnson, Springfield
Albert W. Ray, Jr., Joliet
John J. Ring, Mundelein
P. John Seward, Rockford
Harry Springer, Winnetka
Fred Z. White (*ex officio*)

Responsibilities and Purposes:

The President-Elect shall serve as the Chairman of the Committee on Planning and Priorities. This Committee shall review the ongoing plans and programs, establish appropriate priorities and develop plans for future programs. In the discharge of its duties it should assist the President-Elect in the formation of his objectives for accomplishment during his term as President.

TASK FORCE ON FINANCIAL AID TO MEDICAL STUDENTS

Fred Z. White, M.D., Chillicothe, *Chairman*
Julian W. Buser, M.D., Belleville
Robert P. Johnson, M.D., Springfield
Eugene P. Johnson, M.D., Casey
Malcolm Major, Urbana
Russell Miller, Chicago
Edgar Staren, Burr Ridge
Cyril C. Wiggishoff, M.D., Chicago

TASK FORCE ON MEMBERSHIP

Cyril C. Wiggishoff, M.D., Chicago, *Chairman*
Brad Epstein, M.D., Chicago
Robert C. Hamilton, M.D., Chicago
Robert P. Johnson, M.D., Springfield
Richard H. Moy, M.D., Springfield
Fred Schwartz, Chicago
Linda Tetzlaff, Chicago
Warren D. Tuttle, M.D., Harrisburg
Lillian Widmer, Lombard

Direct Reporting Committees of the House of Delegates

JUDICIAL PANEL COMMITTEE

	Term Expires
Frank B. Norbury, Jacksonville, *Chairman*	1983
Donald Aaronson, Niles	1982
Allison Burdick, Jr., Oak Park	1984
Eugene P. Johnson, Casey	1986
Eugene T. Leonard, Rockford	1985

Responsibilities and Purposes:

The Panel, whose members are nominated by the President and elected by the House of Delegates, adjudicates disputes arising from charges of unethical or illegal practices. The panel accepts appeals after a case has been heard at the county or district level.

Other Appointments and Representatives

REPRESENTATIVES TO STUDENT LOAN FUND BOARD

Jack Gibbs, Canton, *Chairman*

Albert G. Bledig, Eldorado

Thomas Schrepfer, Havana

Responsibilities and Purposes:

ISMS representatives on the Student Loan Fund Board are responsible to the Board of Trustees in matters related to administration of the Student Loan Program operated jointly with the Illinois Agricultural Association.

REPRESENTATIVES TO INA-ISMS JOINT PRACTICE COMMITTEE

Loren Boon, Danvers
Audley F. Connor, Jr., Chicago
Allan Goslin, Streator
Risher Watts, Chicago

Responsibilities and Purposes:

The purposes and objectives of the committee shall be to: (1) improve communication between medicine and nursing to enhance joint planning and action; (2) examine roles and functions in medical and nursing practice with definition of new and altered patterns; (3) propose changes in educational patterns and relationships that would enhance the new role functioning of nurses and physicians; (4) define, identify and examine health care needs; (5) address the traditional problems which affect nurse-physician relationships in order to establish enhanced role functioning, and (6) identify and address the ensuing problems related to basic role reorganization.

REPRESENTATIVES TO ILLINOIS COOPERATIVE HEALTH DATA SYSTEMS

Audley F. Connor, Jr., Chicago
Alexander Goldstein, Harrisburg
Allan L. Goslin, Streator
Donald H. Hanscom, Hinsdale
Henrietta Herbolsheimer, Chicago
Don Kline, Peoria
Alexander R. Lerner, *Executive Administrator,* ISMS
Joseph R. O'Donnell, Glen Ellyn
Clifton L. Reeder, Wilmette
Walter Stevenson, Quincy
Ben T. Williams, Urbana

REPRESENTATIVES TO ILLINOIS STATE COST CONTAINMENT COMMITTEE

David S. Fox, Chicago
Robert R. Hartman, Jacksonville
J. M. Ingalls, Paris
Clifton Reeder, Wilmette
P. John Seward, Rockford
Fred Z. White, Chillicothe

Responsibilities and Purposes:

This committee—co-sponsored by ISMS, Illinois Hospital Association and the Federation of American Hospitals—was created to implement the National Voluntary Effort program in Illinois. Its goals are to: (A) Bring the rate of increase in hospital costs in line with the growth in the Gross National Product; and (B) Reduce capital expenditures for new hospital plants and equipment.

ISMS REPRESENTATIVES TO OTHER GROUPS

Swanberg Foundation, Quincy
Robert R. Hartman, Jacksonville

Liaison to Ill. Soc. of the Amer. Assoc. of Med. Assts.
Robert R. Hartman, Jacksonville

Ill. Interagency Coun. on Smoking and Disease
Charles L. Swarts, Oak Park

Illinois Medical Records Assoc.
Clifton Reeder, Wilmette

Illinois Migrant Council
Raphael Campinini

MD Committee on Optometry
Joel Kaplan, Chicago

Statewide Cooperating Organizations Committee of the Commission on Children
Daniel Pachman, Chicago

Illinois Cancer Council
Peter Friedell, Chicago

Citizens Committee for an Illinois Program to Control High Blood Pressure
ISMS Staff

U.S. Pharmacopaeia
Joseph Skom, Chicago
Vincent Costanzo, Chicago, *Alternate*

ISMS SERVICES

Note: An organizational chart and detailed description of staff functions will be published in the January issue of *IMJ*.

Members of the Illinois State Medical Society benefit from a range of programs, publications and services. This section is designed to describe the activities and organization of the Society and benefits of membership.

ADMINISTRATION

The Executive Administrator is responsible for the implementation of established policy, fiscal, budgetary and personnel matters. Specifically, he:

* provides liaison with the Board of Trustees and implements their actions
* evaluates legal inquiries for referral to the general counsel
* has final authority for management team program planning and implementation
* provides guidance to officers, trustees, committee chairmen and county medical society officers
* directs activity and organization of personnel
* acts as secretary-treasurer for Illinois State Medical Insurance Services

Administrative staff also offer direct support to the House of Delegates, Executive Committee and Committee on Constitution and Bylaws.

MANAGEMENT

Society programs, issues and activities which are complex and broad in nature are coordinated through management team program planning. The Associate Administrator and two staff managers regulate this administrative component under direction of the Executive Administrator. These staff members head designated teams composed of division directors and other personnel. Teams conceptualize, plan and carry out activities to meet the Society's objectives.

The Manager for Public and Governmental Affairs directs this team approach to legislative activity and professional relations requiring combined expertise in legislation, regulations, health planning and third party reimbursement. He also staffs the Committee on Planning and Priorities.

The Manager for Medical Practice and Scientific Affairs directs team approaches to services and projects in education, communications and medical services. In addition to this activity, continuing projects include:

* *Loss Prevention Education*—Physicians and attorneys expert in professional liability serve as faculty for programs conducted by the Committee on Loss Prevention Education. The effort is intended to help physicians become aware of potentially liable situations. County medical societies and hospitals sponsor the programs.
* The *Educational and Scientific Foundation*—This administrative agency of the Society oversees projects in the public interest which cannot be funded by the parent organization.
* *Scientific Speakers Bureau*—Clinical presentations and county medical society meetings are organized through the Scientific Speakers Bureau. Programs in clinical medicine are supported by a grant from Merck, Sharpe & Dohme. A special adjunct to the Speakers Bureau is funded by a grant from the Division of Alcoholism, IDMHDD. This speakers' roster provides education in treatment of alcoholism.
* *Policy Review*—He also staffs the Policy Committee.

MEMBERSHIP BENEFITS

A number of programs and services are provided to Society members or sponsored for their benefit. These include the 50-Year-Club, meeting services and travel programs.

* The *50-Year-Club* consists of physicians who graduated from medical school more than 50 years ago. An annual luncheon gives retired members an opportunity to renew friendships.
* ISMS *meeting services* include provision for assemblies of the House of Delegates and Board of Trustees. Councils and committees meet in the headquarters office.
* Society-sponsored *travel programs* enable members to enjoy luxury cruises and tours at minimum cost. Qualified tour agencies are screened for professional, non-regimented trips.

FINANCE

Accounting and business management services are conducted under policies set by the Board of Trustees and Finance Committee. The ISMS computer is central to these activities. The computer services provide a cost-effective means to:

* maintain membership records
* provide central dues billing and collection for county medical societies
* catalogue claim statistics and other data for the Illinois State Medical Insurance Services

EDUCATION

The Society monitors changes in medical education, postgraduate requirements for licensure and accreditation procedures. Educational matters are addressed through staff services to the Illinois Council on Continuing Medical Education, ISMS Council on Education and Committee on CME Accreditation. Liaison with appropriate state agencies assures that members can be assisted in fulfilling licensure requirements and procedures.

COMMUNICATIONS

The Society provides information and services to membership and media on pertinent topics.

* Speeches, slide presentations and brochures are prepared under direction of the Council on Public Relations and other committees
* News releases publicize ISMS actions and views
* Public service announcements are designed and distributed to Illinois radio and television stations

A number of publications are produced in the Society offices for members and affiliate groups.

* The *Illinois Medical Journal* is published monthly under direction of a Publications Committee and clinical supervision of an Editorial Board. The *Journal* seeks to keep members aware of scientific, economic, legal and political events.
* *Action Report,* a periodic newsletter, focuses on Society activities and economic matters.
* *On the Legislative Scene* is a newsletter available on request during the General Assembly session. *OLS* gives status reports on pending legislation of importance to physicians.
* *AID* (Athletics, Injury and Disease) is a newsletter for coaches and trainers. It gives sports-medicine information in prevention, recognition and triage of injuries and illnesses. *AID* is published three times annually and distributed to about 2000 junior and senior high school coaches and trainers.
* The *Exchange Commentary,* published by the Illinois State Medical Inter-Insurance Exchange, updates ISMIS members on professional liability issues.
* *Pulse of the ISMS Auxiliary* is a quarterly publication of the 3,000 member ISMS Auxiliary. It features membership activities and items of interest to physician spouses.
* Affiliate group newsletters include the Illinois Psychiatric Society *Examiner,* which won a national editorial award in 1980. Other affiliate groups publishing newsletters through Society services are the Illinois Academy of Pediatrics, Illinois Association of Ophthalmology and Illinois society, American Association of Medical Assistants.

In addition to publications, the Society provides services to affiliated groups on a cost allocated basis. These include routine office management, meeting arrangements, membership promotion and records, dues collection and accounting services.

New Physicians

Medical students and residents have formed affiliate sections within the Society. ISMS also conducts several programs for new physicians and those seeking either a medical education or an opportunity to practice in Illinois.

* The *Physician Recruitment Program* seeks to link communities in need of a physician with those seeking practice opportunities. Questionnaires on educational background, interests and practice preference are distributed to physicians who receive a complete list of openings in return. Communities seeking physicians contact the Service, which arranges liaison.
* The *Medical Student Loan Fund Program* is a joint effort of ISMS and the Illinois Agricultural Association. The Medical Student Loan Fund Board screens students whose college grades or MCAT scores are marginal and recommends special consideration by the UI College of Medicine in selected cases. In return, the student promises to practice in a rural community needing a physician for four or five years after graduation.
 The program also makes low interest loans available to students. Repayment is delayed until four years after graduation and the student makes a similar agreement to practice for a period in rural Illinois.
* The *MECO* (Medical Education Community Orientation) program seeks to encourage students to select careers in primary care.

MEDICAL SERVICES

ISMS councils and committees direct activities in areas relevant to medicine and public health. These include:

* health care delivery
* the practice environment
* worker's compensation
* mental health and addictions
* medical-legal concerns
* peer review and ethics
* sports medicine

The Society's public service activities include community education and liaison with public, governmental, professional and private groups.

* The *Jail Health Program* is a project to improve health care in county jails. Technical assistance is given jail sites. Staff supports a steering committee of penal medicine experts.
* The *Statewide Blood Banking Coordinating Committee* seeks to eliminate competition among collection agencies, improve cooperation between regional blood centers and ensure efficient management of blood resources. The Committee plans to coordinate donor recruitment, inventory and distribution. ISMS serves as advisory and mediating body.
* The *Impartial Medical Testimony* program provides physician expert witnesses to the Illinois courts. Impartial examiners are ordered by the court when objective medical data and opinion are needed for litigation. A similar service is provided the Supreme Court Attorney Registration and Disciplinary Commission and Illinois Industrial Commission.

PROFESSIONAL RELATIONS

The Society provides direct services to members through field service representatives. These persons represent ISMS at meetings of component societies, allied professions and government agencies. They serve trustees, officers, county medical society executives and the general membership. Specific professional relations activities include the following:

* *President's Tour*—The ISMS president visits each trustee district during his term of office. The tour includes press conferences, interviews and speaking engagements.
* *Medicare, Medicaid and CHAMPUS Assistance*—Medicare peer review and professional relations services are provided. Liaison with the Illinois Department of Public Aid assures that member concerns are represented when policy changes are considered. Assistance can be provided in payment delays, reimbursement errors, lost billings and fiscal audits.
* *Health Planning*—Actions of the Statewide Health Coordinating Council, Illinois Health Facilities Planning Board and local Health Systems Agencies are followed closely.
* *Third Party Payors*—The Council on Economics and Committee on Third Party Payment Processes direct association with insurance carriers and government bodies that affect their actions.
* *Health Data*—Governmental requirements for statistical information on health care and planning agencies in that area are monitored.

LEGISLATIVE ACTIVITIES

One in five bills introduced in the General Assembly relates to health. The Society's active legislative program is conducted under direction of the Governmental Affairs Council.

All state and national health legislation is monitored. Society staff forward bills to physician members with pertinent expertise for review and comment. When adequate review is completed, bills are either supported or opposed by legislative representatives.

Physicians who testify before legislative committees provide essential background to lawmakers. Additional input and citizen involvement are developed through the Key Man Program and public affairs activity.

* The *Key Man Program* is a network of physicians who are relatives, friends or campaign supporters of Illinois legislators. Key men advise legislators on health legislation.
* *Public affairs activity* includes sponsorship of civic speakers at Society meetings and liaison with government agencies.

COMMERCIAL INSURANCE PROGRAMS

The ISMS Insurance Committee has selected insurance programs which are administered by an independent broker. Each has been scrutinized for quality and economy. Detailed information on ISMS insurance plans and applications may be obtained through the broker, Corroon and Black of Illinois, Inc., 135 S. LaSalle St., Chicago IL 60603; (312-621-4909). It is recommended that members check with ISMS or its broker before purchasing any insurance. A brief synopsis of each program is provided on the following page.

Group Term Life Insurance

The group term life insurance program is underwritten by the North American Company for Life and Health Insurance. It offers:

* $25,000 to $1 million in level term life insurance
* built-in waiver of premium
* availability to members, their spouses and employees under age 65
* coverage to $5,000 for members' children
* non-cancellable, guaranteed renewability to age 100
* conversion to permanent individual policy guaranteed to age 65

Group Disability Income Protection Program

The group disability income program is underwritten by the Commercial Insurance Company. It provides:

* $100-$400/week for total disability
* coverage renewable to age 70
* benefit period options of lifetime accident and sickness payable (1) to age 65; (2) for seven years; (3) for one year
* available to members and authorized employees or insured members to age 56
* benefits payable regardless of other insurance
* no restrictive riders attached after issuance
* individual coverage cannot be terminated

Professional Overhead Expense Plan

This new plan is underwritten by the Hartford Accident and Indemnity Company and provides

* $500-$5,000/month coverage
* office overhead expenses paid to maximum benefit selected beginning with 31st day of total disability
* benefits payable to 24 months regardless of other insurance
* new—accumulation benefit provided
* guaranteed issue for qualified new members under age 40 who apply within 60 days of effective date of membership
* available to all members under age 65 in full time practice
* rent, utilities, employee salaries and monthly pro rata of specified annual fixed expenses customary to the profession
* premiums deductible for individuals and partnerships under Revenue Ruling 55-264

The plan does not cover personal income, salaries for other physicians, principal payments on debts, implements, pharmaceutical products and personal insurance premiums.

Group Major Medical

The group major medical plan is underwritten by the Commercial Insurance Company. It provides that the insured select a calendar year deductable of $500 or $1000, which applies to each insured person. It then will *cover 80% of the following:*

* $150/day room and board rate
* (additional) $150/day in an ICU
* hospital supplies and services, physician services, anesthetists, diagnostic lab and X-ray, registered nurses, ambulance services, prescription drugs and medicines, physiotherapy, therapeutic equipment rentals, artificial limbs, oxygen and blood.

The plan is available to all members and qualified employees of insured members under age 65.

Excess Major Medical

This plan, underwritten by the Sentry Insurance Company, pays 100% of eligible medical expenses to ten years or $500,000. Selection of a $15,000, $20,000 or $25,000 deductible is available. The plan comes into effect when eligible medical expenses incurred within a three year period exceed the deductible. Evidence of insurability is not required. The plan will compensate up to 100% of the following:

* medical care
* physician medical care and treatment
* semi-private room and board
* private duty nursing services
* convalescent home confinement (up to $50/day and 90 days/year)
* physiotherapy by licensed physiotherapist
* prescription drugs, medicine and antibiotics
* dressings, casts, splints, trusses, braces and crutches; rental of wheelchair, hospital-type bed, iron lung and other therapeutic equipment; blood and blood plasma; X-ray and other radiotherapy; diagnostic tests and examinations; dental care for accidental injury of natural teeth; oxygen and anesthesia; ambulance service to $200 in any six month period; assistant surgeon to 20% of eligible expenses for chief surgeon; anesthesiologist to 15% of eligible expenses of chief surgeon.

The plan is available to members and their spouses, unmarried children under 25 and eligible full time employees under 65. Eligible applicants are guaranteed acceptance subject to a pre-existing conditions limitation.

Hospital Indemnity Plan

The Hartford Accident and Indemnity Company underwrites the ISMS-sponsored hospital indemnity plan. Available plans provide benefits of $27.50, $55.00, $110.00 or $165 per day of hospital confinement. Benefits are also:

* initiated with first day of confinement
* payable to 365 days for each cause of confinement
* automatically doubled for hospital stays due to cancer or confinement in an ICU for persons under age 65
* payable regardless of other insurance

All members, their employees and families may participate. Acceptance of eligible applicants during special enrollment periods is guaranteed, subject to a pre-existing conditions limitation.

Worker's Compensation

Policies issued by the Casualty Reciprocal Exchange, a member of the Dodson Insurance group, are administered under the Dodson Savings Plan. Specific aspects include the following:

* return declared at the end of each premium year on the basis of loss experience—savings are returned to policyholders
* rates standard and approved for class of employment
* savings paid as earned within approximately 90 days of policy expiration or on completion of payroll audits

Accidental Death and Dismemberment

An accidental death and dismemberment plan is underwritten by the Hartford Accident & Indemnity Company. It provides coverage:

* for members, their spouses, children and employees
* a 24-hour business and pleasure coverage from $25,000 to $250,000
* renewable to age 70

Estate Planning

Corroon & Black of Illinois, Inc., offers estate planning services. These include:

* educational programs for county society meetings
* individual counseling

Ancillary Organizations

Illinois State Medical Society Auxiliary

The Illinois State Medical Society Auxiliary is a unique organization composed entirely of physicians' spouses who give their time and talents to promote health awareness, medical legislation and funds for medical research and education (AMA-ERF).

The Illinois State Medical Society Auxiliary had its inception in the parlor car of a speeding train in 1927. Dr. and Mrs. G. Henry Mundt were returning from the AMA meeting in Washington, D.C. and had learned of the existence of the AMA Auxiliary and of 22 functioning state auxiliaries. Mrs. Mundt was persuaded to undertake the task of organizing an auxiliary in Illinois and to seek the approval of the Illinois State Medical Society's House of Delegates. On May 31, 1927, the ISMS House of Delegates endorsed the organization of an auxiliary in Illinois and urged the county societies to assist in promoting auxiliary membership.

The first formal meeting of the Auxiliary was held at the LeClaire Hotel in Moline on June 2, 1927 with 25 members present. In 1928, the organization became permanent. Today, we have a membership of 3300 and can look with pride on the auxiliary's accomplishments.

The auxiliary has instituted a large number of successful community health programs (*eg.* Vial of Life, Nutrition, Physical Fitness, Stress Management, Child Seat Belt Safety, Immunization). We have striven to educate the public on cost effective use of the medical care system and we have been highly successful in fund raising to provide financial assistance to medical students and medical schools (AMA-ERF).

Although we can look with pride upon what we have done, there is much that remains to be accomplished. For example, we will be increasing our fund-raising activities for medical education and research (AMA-ERF). Volunteer organizations such as ours will be assuming a primary role in dealing with society's health problems. We must work to convince other physician spouses that participating in Auxiliary activities is a worthwhile investment of time. Greater involvement with spouses of medical students and residents is encouraged through the SASII program (Sponsor A Spouse In Illinois). On the legislative scene, we provide information on health-related legislation, are a part of a legislative alert system and engage in face-to-face contact with legislators.

We recognize that it is our responsibility to provide leadership education for our up and coming county, state and national leaders. Thus, the inception of the State Leadership Seminars and participation in the AMA Auxiliary Confluence in October for county presidents-elect. We use our "PULSE" publication to communicate with the membership.

We are also concentrating our efforts on a closer working relationship with ISMS, as together, we meet the challenges of medicine in the '80's.

Mrs. Harold Keegan

OFFICERS

President Mrs. Harold Keegan, Kankakee
President-Elect Mrs. Don Hinderliter, Rochelle
1st Vice President
(Membership Coordinator) Mrs. Gamil Arida, Joliet
2nd Vice-President
(Program and Project Bank
Coordinator) Mrs. Selig Hodes, Forreston
3rd Vice-President
(Health Projects
Coordinator) Mrs. Irvin Blumfield, Alton
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Mrs. Jane Swanson
104 E. Broadway, Suite 5, Monmouth 61462

PARLIAMENTARIAN

Mrs. Francis Graff, Freeport

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Fitness Mrs. Alex Spadoni, Hinsdale
Health Awareness-Immunization
Co-Chairman Mrs. Jack Brodsky, Champaign
..... Mrs. Charles VanGorder, Geneva
Vial of Life and
Medical Marriage..... Mrs. Fred Nathan, Rockford
Child Seat
Belt Safety Mrs. Ronald Severino, Wheaton
Cult Awareness Mrs. George Olander, Lake Forest
Exceptional Person
Awareness Mrs. Gene Hoerr, Peoria
Humanitarian Award ... Mrs. M.W. Hollowell, Charleston
Leadership Seminar
Coordinator..... Mrs. Harlan Failor, Champaign
Legislation..... Mrs. Alan Taylor, Danville
Long Range Planning Mrs. Don Hinderliter, Rochelle
Members-at-Large Mrs. Robert Reardon, Bloomington
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Benevolence Mrs. Louis Tarsinos, Princeton
Governmental Affairs..... Mrs. Alan Taylor, Danville
Medical Services Mrs. Selig Hodes, Forreston
Mental Health and
Addiction..... Mrs. Alex Spadoni, Hinsdale
Public Relations &
Membership Mrs. Gamil Arida, Joliet

American Association of Medical Assistants, Illinois Society

The American Association of Medical Assistants is a national, non-profit organization dedicated to the professional advancement of medical assistants. This tri-level structure—similar to AMA—encompasses local, state and national affiliation.

Membership in the Illinois Society, AAMA, is open to medical assistants, office nurses, technicians, secretaries, bookkeepers and clerks performing administrative and/or clinical duties under the direct supervision of a physician. College students attending Medical Assistant Programs are encouraged to belong. Physician advisors at all three levels assist with educational endeavors.

The state society's numerous professional, educational programs in various parts of the state offer continuing education units (CEU) to its participants. Some of the major programs are:

Travel Course, Regional Seminars, Annual Symposium, Personal Development Day and the All Day Workshop held in conjunction with Chicago Medical Society's Midwest Clinical Conference. The annual three day meeting in April includes excellent lectures, study programs and the culmination of association business during the House of Delegates Session.

The American Association of Medical Assistants encourages advancement of medical assistants by offering a certification examination designed to evaluate professional competency. Local chapters, in addition to their regularly scheduled monthly educational programs, conduct preparatory classes in terminology, physiology, anatomy, human relations, patient contact, medical law and ethics, communications, bookkeeping, insurance, administrative procedures, laboratory orientation and collection methods. The certification examination is administered twice a year.

The medical assistant may become a Certified Medical Assistant (CMA) by successfully passing the special board examination and meeting qualifying criteria of the American Association of Medical Assistants. Specialty examinations are given in Administrative, Clinical and Pediatric divisions. For further information about this program contact the American Association of Medical Assistants, One East Wacker Drive, Chicago, Illinois 60601.

Members interested in independent continuing education through a "home study" program may purchase and utilize audio cassettes and workbooks. The president of the Illinois Society communicates, via the "Executive Memo" (a monthly publication), with nearly 500 members giving pertinent information of current activities.

A quarterly publication "The Illini Cardinal" concentrates on educational topics and is available to all members without additional cost. "The Professional Medical Assistant," the official bi-monthly journal of the association, is largely devoted to original articles written for medical assistants by their peers or other professionals in related fields. It is an automatic benefit of membership, although subscriptions are available for non-members. There are many other benefits available (*i.e.* group insurance). During the Annual Meeting of AAMA each fall, a variety of experts in medical and related fields address participants during educational programs and workshops.

Monthly educational meetings are scheduled in the following chapters: Cook County-Chicago (downtown), Southwest Suburban (Oak Lawn), Northwest (Arlington Heights), Northshore (Skokie), West Cook (River Grove), Cook County South (Dolton), Aux Plaines (Oak Park), DuPage (Wheaton), Coles-Cumberland (Charleston), DeKalb (Sycamore), LaSalle, Macon (Decatur), McLean (Bloomington), McHenry, Morgan-Scott (Jacksonville), Peoria, Randolph (Chester), Rock Island, Sangamon (Springfield), St. Clair (Belleville), Spoon River Valley (Canton), Vermilion (Danville), Will Grundy (Joliet)

and Winnebago (Rockford). Physicians in these areas are asked to encourage their medical assistants to join the association and actively participate in the selection of educational programs that will enable the members to become better medical assistants.

For membership information please contact Mary Lu Ostrowski, CMA, Pres., 1704 E. Jackson St. Bloomington, IL 61701 or Elaine Kaiser, CMA-A, 9103 Sandpiper Ct. Orland Park, IL 60462.

OFFICERS

President—Mary Lu Ostrowski, CMA, Bloomington, Il
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Leslie Schwartz, M.D., Chicago
Robert Hartman, M.D., Jacksonville, *Liaison to ISMS*
Allison Burdick, Sr., M.D., Chicago, Emeritus Member

The Educational & Scientific Foundation

The Educational & Scientific Foundation was founded to provide an administrative agency to foster the advancement of clinical science through:

1) The initiation of scientific and medical research activities.

2) The collection, evaluation and dissemination of the results of research activities to the public.

3) The implementation and management of projects related to medicine for individuals, or organizations seeking to inform or educate others, or to improve their own knowledge.

The Foundation is a distinct corporate entity which has an interlocking Board with the Illinois State Medical Society. It is staffed through ISMS headquarters.

The ISMS immediate past president serves as chairman of the Foundation's Board of Directors.

Board of Directors

Herschel Browns, Chicago, *Chairman*
Morris T. Friedell, Chicago
Eugene P. Johnson, Casey
Fred Z. White, Chillicothe
Cyril C. Wiggishoff, Chicago

Illinois Council on Continuing Medical Education

This Council was created by the Illinois State Medical Society, in co-operation with the state's eight medical schools, to fulfill these purposes: (a) encourage and assist in the development of continuing medical education programs for Illinois physicians that will enhance patient care; (b) study and encourage development of new educational methods, techniques, systems, *etc.;* (c) assist learning sources to identify the educational needs of Illinois physicians; and (d) stimulate, motivate, and encourage physicians at all levels throughout the state to participate in formal continuing educational programs.

ICCME was proposed by Dr. Edward W. Cannady in his 1969 inaugural address as President of ISMS. Following careful study, the 1970 House of Delegates approved the plan in principle. The next President, Dr. J. Ernest Breed, vigorously pursued the idea; after the 1971 House of Delegates voted initial funding, he also served as Chairman of the Organizing Committee.

ICCME was officially chartered by the state as a nonprofit educational organization in May, 1972, and began operations with the appointment of its first Executive Director in September, 1972. Financial support of the Council is provided primarily by ISMS members' dues.

ICCME unites the resources of the Illinois State Medical Society and the educational resources of the state's medical schools; *and* independent in action, it serves *all* interests concerned with CME and thus provides a crucial channel of communication to co-ordinate the efficient use of all available resources.

Current Major Activities

1. Sponsor an annual Congress on Continuing Medical Education, to involve all elements of the Illinois health-care system in the Council's work. The tenth Annual Congress will meet in 1982.
2. On behalf of ISMS, perform staff work for accreditation of intrastate CME including advice on preparing to apply for accreditation.
3. Advise hospitals and other organizations on effective CME planning and organization.
4. Organize workshops on techniques of CME—including an unusual "Seminar on CME Leadership" for leaders of hospital medical staffs and medical societies.
5. Develop and publish CME planning aids that offer practical advice and important background on effective or-

ganization of CME. Included are *Your Personal Learning Plan,* a unique handbook offering advice on how to plan your learning most effectively; and *How to Start a CME Program in Your Hospital or Medical Society* for CME planners. For all items now available, request "The Illinois Handbook on CME Planning—Catalog/Order Form." All publications are available to ISMS members at a 50% discount. To obtain a copy of the Catalog/Order Form just indicate this on your prescription form and mail to ICCME, 55 E. Monroe, Chicago, IL 60603.

6. Prepare a monthly calendar of Illinois CME activities for *IMJ.*
7. Plan and conduct research studies that contribute to the improvement of CME methods.

Organization & Governance

Members of the ISMS Executive Committee serve as legal members of the ICCME Corporation, set basic policy, and elect the Board of Directors.

The affairs, property, and business of the Council are managed by a Board of Directors comprised of: nine practicing physicians representing the State Medical Society; and eight academic physicians, one selected by each dean of an Illinois medical school.

Board of Directors*

Donald F. Pochyly, M.D., M.Ed., Hines, *President*
Ernst C. Bone, M.A., M.D., Jacksonville, *Vice-President*
Roger A. Wujek, Litchfield, *Treasurer*
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Harold A. Paul, M.D., M.P.H., Chicago
Ward E. Perrin, D.O., F.A.C.O.I., Chicago
Robert Prentice, Springfield
Fred Z. White, M.D., M.A., Chillicothe

*All above are physicians unless otherwise indicated.

EXECUTIVE DIRECTOR: Leonard S. Stein, Ph.D.

ASS'T. EXECUTIVE DIRECTOR: Thomas G. Pearson, Ed.D.

Panel of Accreditation Site Visit Surveyors

Serving as Surveyors are Board Members of the Illinois Council on Continuing Medical Education and others chosen by the ICCME Board who meet criteria adopted by the ISMS Board of Trustees March 31, 1979. ICCME does *not* make accreditation decisions, neither individual Board Members nor the Board collectively. Rather, the Survey Team's role is analogous to that of the physician who performs a physical examination on a potential purchaser of life insurance: to ascertain and report the facts, leaving to the underwriter the actuarial decision on granting insurance. The Survey Team makes a judgment on each of the seven "Illinois Criteria," on the basis of point values prescribed by the ISMS Committee on CME Accreditation, as well as the Team's conversation with the Sponsor. Individuals serving on the Panel of Surveyors, in addition to members of the ICCME Board, are (all are physicians unless otherwise indicated):

Philip D. Anderson, M.D., Ph.D.
Lloyd Barr, Ph.D.
Bradford W. Claxton, M.Ed.
Anthony L. Barbato
Joseph L. Daddino
John G. Demakis
Richard E. Dukes
Sherman Elias
L. Penfield Faber
Charles G. Farnum, Jr.
Peter O. Fried
Allan L. Goslin
Robert C. Hamilton
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John M. Holland
Kathryn S. Huss
Ross N. Hutchison
William L. Jackson
Harold L. Jensen
Frank J. Jirka, Jr.
Eugene P. Johnson
James M. Laidlaw
Howard B. Levy
Paul A. Maxwell, Jr.
Boyd E. McCracken, Sr.
Charles T. McHugh
Morgan M. Meyer
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Joseph B. Perez
Mather Pfeiffenberger
Eugene Scherba
Joseph C. Sherrick
George Shropshear
Robert C. Stepto
Jacob R. Suker
L. W. Tanner
Sheldon S. Waldstein
Charles J. Weigel
George T. Wilkins, Jr.

Illinois Foundation for Medical Care

The Illinois Foundation for Medical Care (IFMC) is a not-for-profit corporation established in 1971 by action of the House of Delegates. Under revised bylaws adopted June, 1977, IFMC is operated under direction of a 6-member Board of Directors elected annually by the ISMS Board of Trustees. The IFMC currently contracts with the Regional Health Resources Center, Urbana, Illinois for administrative services.

IFMC maintains relationships with the several local foundations for medical care and is available to serve their needs on a cost reimbursement basis.

IFMC Board of Directors

Joseph Sherrick, M.D., Chicago, *President*
Robert P. Johnson, M.D., Springfield, *Vice-President*
James Laidlaw, M.D., Champaign, *Secretary-Treasurer*
Audley F. Connor, M.D., Chicago
Robert Prentice, M.D., Springfield
Lawrence L. Hirsch, M.D., Chicago

Illinois State Medical Society Political Action Committee (IMPAC)

The Illinois State Medical Society Political Action Committee (IMPAC) is a voluntary, non-profit, unincorporated, permanent membership organization founded in 1960. IMPAC serves as the unified political action arm of Illinois physicians and their spouses. Funds collected through IMPAC memberships, used in support of candidates, are administered independently of other professional groups. However, the program is operated in harmony with the legislative objectives of the Illinois State Medical Society. Individual participation in IMPAC is one means by which the individual physician and his spouse can effectively participate in public affairs.

IMPAC participates primarily in election contests for legislative offices—both those in the Illinois General Assembly and in the U. S. Congress.

IMPAC's organization consists of a chairman, an executive committee, and a council. Political action activities are implemented by local physician support committees formed on behalf of candidates in U. S. Congressional or other legislative districts. Candidate selection and support are determined on the basis of evaluations and recommendations submitted to the council and executive committee by the local committees, thus assuring members of a "grass roots" voice in IMPAC activities.

Additional information about IMPAC may be obtained by writing: IMPAC, Suite 3510, 55 E. Monroe, Chicago 60603.

Illinois State Medical Insurance Services, Inc.

Illinois State Medical Insurance Services is an Illinois corporation, formed in March, 1976, all of whose capital stock is owned by the Illinois State Medical Society. Its sole business is to act as Attorney-in-Fact for the Illinois State Medical Inter-Insurance Exchange.

The Exchange was organized to provide comprehensive professional liability insurance for Illinois physicians. Its membership is limited to members of the Illinois State Medical Society.

Insurance Services provides all the management and underwriting services required for the operation of the insurance business of the Exchange. It does so under Power-of-Attorney granted it by the Exchange in a management agreement and by each member of the Exchange through his application for membership. Under the management agreement the Board of Governors of the Exchange prescribes policy to be followed in the conduct of the business; within the guidelines established by these policy statements, Insurance Services manages the business of the Exchange, accepting or rejecting applications, determining the form of insurance policies, handling and disposing of claims, and performing all related functions. Insurance Services is compensated by the Exchange on the basis of expense reimbursement; it is not anticipated that Insurance Services will produce any operating profit.

The organization of Insurance Services comprises three principal functional divisions: Underwriting and Risk Management, Claims, and Administrative Services. Advisory and consultative services are provided by member physicians through a review system organized and directed by the Medical Director of Insurance Services. Financial and accounting services are provided by staff of the Illinois State Medical Society, whose Director of Finance serves as Controller of Insurance Services. The offices of Illinois State Medical Insurance Services, Inc., are at 55 East Monroe Street, Suite 3440, Chicago, Illinois 60603.

Board of Directors

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Alfred Clementi
Robert Hamilton
J. M. Ingalls
Clifton L. Reeder
Warren D. Tuttle

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Kurt Elward, Vice Chairman
Linda Tetzlaff, Secretary
Ronald Davis, Delegate
Malcolm Major, Alternate Delegate

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Loyola University
Ed Kaplan
Northwestern University
Dirk Proffer
Rush Medical College
Beth Pletcher
Southern Illinois University—Springfield
Dale Bramlet
Southern Illinois University—Carbondale
Peter Benson
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University of Illinois—Champaign/Urbana
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Don Matsunaga
University of Illinois—Rockford
Janet Schmidt
Chicago College of Osteopathic Medicine
John Dolehide

Responsibilities and Purposes

The purposes of the Medical Student Section shall be to encourage and support the active participation of medical students in the ISMS and to provide a representation of student opinions and ideals in organized medicine. In addition, the Medical Student Section shall support the purposes of ISMS as stated in its Constitution. The Medical Student Section is composed of all student members of ISMS.

Resident Physicians Section

Larry Gratkins, *Chairman*
Brad Epstein, Vice-Chairman
David Palmer, Secretary
William E. Golden, Delegate
John Hall, Alternate Delegate

House Staff Organization Presidents/Representatives

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Inst. of Physical Medicine & Rehabilitation
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Northwestern Memorial Hospital
Kimberly Johnson, Chicago
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Robert Eilers, Chicago
Rush-Presbyterian-St. Luke's Hospital
Randy Epstein, Chicago
St. Elizabeth's Hospital
Abimael Perez, Chicago
St. Francis Hospital
Michael S. Caldwell, Peoria
Southern Illinois University Affiliated Hospitals
Alan Birtch, Springfield
University of Illinois
Gregory A. Shove, Chicago
Daniel Haller, Peoria
Jay Goldstein, Chicago

Responsibilities and Purposes

The purposes of the Resident Physicians Section shall be to encourage and support the active participation of physicians in training in the Illinois State Medical Society and to provide representation of intern-resident opinions and ideas in organized medicine. In addition, the Resident Physicians Section shall support the purposes of the ISMS, as stated in its Constitution. All in-training members of the ISMS shall be members of the Resident Physicians Section, having the right to vote and hold office.

MEDICAL AND ALLIED HEALTH EDUCATION

MEDICAL SCHOOLS IN THE STATE OF ILLINOIS

University of the Health Sciences/The Chicago Medical School
2020 W. Ogden Ave., Chicago, 60612
Northwestern University Medical School
303 E. Chicago Ave., Chicago, 60611
University of Chicago-Pritzker School of Medicine
950 E. 59th Street, Chicago 60637
University of Illinois College of Medicine*
Chicago Campus—
1853 W. Polk Street, Chicago, 60612
Loyola University, Stritch School of Medicine
2160 S. First Ave., Maywood, 60153
Rush Medical College
1725 W. Harrison St., Chicago 60612
Southern Illinois University School of Medicine
801 N. Rutledge, P.O. 3926, Springfield, 62708

*Note: This is the parent college for Abraham Lincoln School of Medicine, Peoria School of Medicine, Rockford School of Medicine and the School of Basic Medical Sciences (Urbana).

ALLIED HEALTH EDUCATIONAL PROGRAMS

Accredited by the American Medical Association Committee on Allied Health Education and Accreditation

CYTOTECHNOLOGIST

CHICAGO—Michael Reese Hospital & Medical Center
Mount Sinai Hospital Medical Center
University of Chicago—Lying-in-Hospital

HISTOLOGIC TECHNICIAN

CHICAGO—Holy Cross Hospital
Mercy Hospital & Medical Center
Mount Sinai Hospital & Medical Center
St. Joseph Hospital
University of Chicago Hospitals & Clinics
PEORIA—St. Francis Hospital and Medical Center
SPRINGFIELD—Memorial Medical Center
St. John's Hospital

MEDICAL ASSISTANTS

BELLEVILLE—Belleville Area College
CARTHAGE—Robert Morris College
PALATINE—William Rainey Harper College
RIVER GROVE—Triton College

MEDICAL LABORATORY TECHNICIAN

BELLEVILLE—Belleville Area College
DIXON—Sauk Valley College
EAST PEORIA—Illinois Central College
ELGIN—Sherman Hospital Association
GODFREY—Lewis & Clark Community College
GRAYS LAKE—College of Lake County
MORTON GROVE—Oakton Community College
OLNEY—Richland Memorial Hospital
PALOS HILLS—Moraine Valley Community College
QUINCY—Blessing Hospital
RIVER GROVE—Triton College

MEDICAL RECORD ADMINISTRATORS

CHICAGO—University of Illinois College of Medicine
NORMAL—Illinois State University

MEDICAL RECORD TECHNICIAN

BELLEVILLE—Belleville Area College
CHICAGO—Central YMCA Community College
EAST PEORIA—Illinois Central College
GRAYSLAKE—College of Lake County
MORTON GROVE—Oakton Community College
PALOS HILLS—Moraine Valley Community College

MEDICAL TECHNOLOGIST

BELLEVILLE—St. Elizabeth Hospital
BLUE ISLAND—St. Francis Hospital
CHAMPAIGN—Burnham City Hospital
CHICAGO—Augustana Hospital & Health Care Center
Holy Cross Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Northwestern University Medical School
Michael Reese Hospital & Medical Center
Rush-Presbyterian-St. Luke's Medical Center
St. Anne's Hospital
St. Joseph Hospital
St. Mary of Nazareth Hospital Center
University of Illinois College of Medicine
V. A. Lakeside Hospital

DANVILLE—Lake View Memorial Hospital
DECATUR—Decatur Memorial Hosiptal
St. Mary's Hospital
EVANSTON—Evanston Hospital
FREEPORT—Freeport Memorial Hospital
HINES—V.A. Hospital
HINSDALE—Hinsdale Sanitarium & Hospital
JOLIET—St. Joseph Hospital
Silver Cross Hospital
MAYWOOD—Foster G. McGraw Hosp./Loyola University
NORTH CHICAGO—University of Health Sciences/ Chicago Medical School
OAK LAWN—Christ Hospital
OAK PARK—West Suburban Hospital Association
PARK FOREST—Governors State University
PEORIA—Methodist Medical Center of Central Illinois
St. Francis Hospital and Medical Center
QUINCY—St. Mary's Hospital
ROCKFORD—Rockford Memorial Hospital
St. Anthony Hospital and Medical Center
Swedish-American Hospital
SPRINGFIELD—St. John's Hospital
Sangamon State University
URBANA—Carle Foundation Hospital
WAUKEGAN—St. Therese Hospital
WINFIELD—Central DuPage Hospital

NUCLEAR MEDICINE TECHNOLOGY

CHICAGO—Illinois Masonic Medical Center
Northwestern Memorial Hospital
St. Mary of Nazareth Hospital Center
HINES—V. A. Hospital
PEORIA—St. Francis Hospital-Medical Center
RIVER GROVE—Triton College

OCCUPATIONAL THERAPIST

CHICAGO—University of Illinois College of Medicine

PHYSICAL THERAPIST

CHICAGO—University of Health Sciences/ Chicago Medical School
University of Illinois College of Medicine

RADIOGRAPHER

ARLINGTON HTS.—Northwest Community Hospital
BELLEVILLE—Belleville Area College
CARBONDALE—Southern Illinois University
CENTRALIA—Kaskaskia College
CHICAGO—Central YMCA Community College
Cook County Hospital
DePaul University
Henrotin Hospital
Illinois Masonic Medical Center
Louis A. Weiss Memorial Hospital
Malcolm X Community College
Michael Reese Hospital & Medical Center
Provident Hospital & Training School
Ravenswood Hospital Medical Center
St. Anne's Hospital
St. Joseph Hospital
South Chicago Community Hospital
University of Illinois Hospital
Wright Junior College
DANVILLE—Lake View Medical Center
DECATUR—Decatur Memorial Hospital
DIXON—Sauk Valley College
EAST PEORIA—Illinois Central College
ELGIN—St. Joseph Hospital
EVANSTON—St. Francis Hospital
GALESBURG—Carl Sandburg College
GLEN ELLYN—College of DuPage
GRAYSLAKE—College of Lake County
HINSDALE—Hinsdale Sanitarium & Hospital
KANKAKEE—Kankakee Community College
KEWANEE—Kewanee Public Hospital
MACOMB—McDonough District Hospital
MALTA—Kishwaukee College
MOLINE—Lutheran Hospital
Moline Public Hospital
MORTON GROVE—Oakton Community College
NORMAL—Brokaw Hospital
OLNEY—Richland Memorial Hospital
PALOS HILLS—Moraine Valley Community College
PEORIA—St. Francis Hospital
QUINCY—Blessing Hospital
St. Mary's Hospital
RIVER GROVE—Triton College
ROCKFORD—Rockford Memorial Hospital
Swedish American Hospital
ROCK ISLAND—Rock Island Franciscan Hospital
SOUTH HOLLAND—Thornton Community College
SPRINGFIELD—Lincoln Land Community College
Memorial Medical Center

RESPIRATORY THERAPIST

CHAMPAIGN—Parkland College
CHICAGO—Central YMCA Community College
Malcolm X College
Northwestern University Medical School
University of Chicago Hospitals & Clinics
MOLINE—Lutheran Hospital
PALOS HILLS—Moraine Valley Community College
RIVER GROVE—Triton College
ROCKFORD—Rock Valley College
SPRINGFIELD—Lincoln Land Community College

RESPIRATORY THERAPY TECHNICIAN

CHAMPAIGN—Parkland College
CHICAGO—Metropolitan Group of Hospitals
Northwestern Memorial Hospital
University of Chicago Hospitals and Clinics
KANKAKEE—Kankakee Community College
MOLINE—Lutheran Hospital
OAK LAWN—Christ Hospital
PALOS HILLS—Moraine Valley Community College
QUINCY—St. Mary's Hospital
ROCKFORD—Swedish American Hospital
SPRINGFIELD—St. John's Hospital
WAUKEGAN—Victory Memorial Hospital

RADIATION THERAPY TECHNOLOGIST

BELLEVILLE—Belleville Area College
CHICAGO—Rush-Presbyterian-St. Luke's Medical Center
South Chicago Community College
ELGIN—St. Joseph Hospital
EVANSTON—Evanston Hospital
St. Francis Hospital
GLEN ELLYN—College of DuPage
HINES—V. A. Hospital
ROCKFORD—Swedish-American Hospital

SPECIALIST IN BLOOD BANK TECHNOLOGY

CHICAGO—Michael Reese Hospital & Medicine Center
Mount Sinai Hospital Medical Center
University of Illinois College of Medicine
PARK RIDGE—Lutheran General Hospital

SURGICAL TECHNOLOGIST

BELLEVILLE—Belleville Area College
CHAMPAIGN—Parkland College
EAST PEORIA—Illinois Central College
MOLINE—Moline Public Hospital
PALOS HILLS—Moraine Valley Community College
QUINCY—Blessing Hospital
RIVER GROVE—Triton College

ILLINOIS STATE GOVERNMENT

The state government is divided into three branches—legislative, executive and judicial. The legislative power is vested in the General Assembly, which is composed of the State Senate and the House of Representatives (a bicameral assembly).

For representation in the General Assembly, there are 59 legislative districts. Each district elects one senator and three representatives. Thus, the Senate has 59 members and the House 177. Under the new constitution, senators are elected for 4 year terms, representatives are elected for 2 year terms.

The General Assembly shall convene each year on the second Wednesday of January. The General Assembly shall be a continuous body during the term for which members of the House of Representatives are elected. The General Assembly's functions are to enact, amend, or repeal laws or adopt appropriation bills, act on amendments to the United States constitution, and act to remove public officials.

When the House of Representatives is organized, a Speaker or presiding officer is elected for the biennium. The presiding officer of the Senate is the President of the Senate. To facilitate the handling of legislation, the members of the Senate and House are assigned to designated committees to consider bills of like subject matter. These committees usually hold public hearings to discuss legislation before the measure is taken up by the entire House or Senate. There are approximately 50 committees.

EXECUTIVE BRANCH

The Constitution provides that the Executive Department shall consist of the Governor, Lieutenant Governor, Secretary of State, Comptroller, Treasurer, and Attorney General. These elected officers of the Executive Branch shall hold office for four years, beginning on the second Monday of January after their election and, except in the case of the Lieutenant Governor, until their successors are qualified. They are elected every four years.

STATE OFFICERS 1981

Governor, JAMES R. THOMPSON, Rep., Chicago
Lieutenant Governor, Vacant
Secretary of State, JIM EDGAR, Rep., Charleston
Comptroller, ROLAND W. BURRIS, Dem., Chicago
Treasurer, JEROME COSENTINO, Rep., Palos Heights
Attorney General, TYRONE FAYNOR, Rep., Evanston
Clerk of the Surpeme Court, CLELL L. WOODS, Springfield

LEGISLATIVE BRANCH

Legislative Procedure

Each member of the General Assembly has the power to introduce bills or resolutions. When a bill is introduced it is read at large a first time, ordered printed, and referred to the proper committee for consideration, except that in case of an emergency, a bill may be advanced without reference to committee. If the committee recommends the bill favorably, it is sent to second reading when amendments to it can be offered for consideration by the entire membership. The bill will then be given a third and final reading after which it is acted upon by the entire membership of the house that is considering it.

Action by Both Houses

To pass, the bill must receive the favorable vote of the majority of the members elected (89 in the House; 30 in the Senate). These bills are then sent to the other house where essentially the same procedure is followed.

If, because of amendments in the second house, there are two versions of the same bill, conference committees may be appointed to work out the differences. Both houses must vote favorably on the same version of the bill before it can be sent to the governor for his consideration.

If the governor thinks the bill should become a law, he will sign it. If the governor decides it would be unwise for the bill to become law, he can veto it. If he vetoes the bill, he must file a statement of objections. Three-fifths of the members elected to each House can override the veto. He can also veto specific items of an appropriation bill and he may reduce an appropriation. The governor may also return a bill to the Legislature with specific recommendations for change, thereby obviating the need of vetoing the entire bill.

Note

A Legislative Directory containing the names and addresses of all members of the Illinois General Assembly and the Illinois Senators and Representatives in the Congress is available. Requests should be directed to: Illinois State Medical Society, Regional Office, 701 S. Second St., Springfield 62704.

DANGEROUS DRUGS COMMISSION

300 N. State Street, Chicago 60610, Phone: 312/822-9860
300 W. Monroe Street, Springfield 62706, Phone: 217/782-0685
Thomas B. Kirkpatrick, Jr., Executive Director

The Dangerous Drugs Commission is the single state agency responsible for all drug abuse treatment and prevention in Illinois, and for the preparation of all drug abuse planning and allocation of state and federal drug abuse funds. Other responsibilities include scheduling of controlled substances, licensing of drug abuse programs and controlled substances research, and training.

Administrative Staff
Daniel W. Behnke, Deputy Director
Barbara Frazin-Weiner, Chief Counsel
Patricia J. Larsen, Special Assistant to the Director
Linda Hargnett, Administrator, Planning and Program Development
Krishan Kaistha, Ph.D., Chief Toxicologist
Benjamin Linsky, Administrator, Management
Felix Matlock, Administrator, Field Operations
Neil A. Reilly, Administrator, Compliance and Enforcement

STATUTORY BODIES

Dangerous Drugs Commission
Ivan Pavkovic, M.D., Chicago, *Chairman*
Gregory L. Coler, Springfield
Edward T. Duffy, Arlington Heights
Gayle Franzen, Springfield
Donald Gill, Springfield
James Jeffers, Chicago
William Kempiners, Springfield
Jeffrey Miller, Chicago
Robin Morgenstern, Chicago
Joseph Skom, M.D., Chicago
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Dangerous Drugs Advisory Council
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David Bingaman, Oak Park
Peg Blaser, Springfield
David Blumenfeld, Esq., Chicago
Supt. Richard Brzeczek, Chicago
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Gary Clayton, Springfield
Richard M. Daley, Esq., Chicago
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Sen. John D'Arco, Chicago
Ronald Dozier, Esq., Bloomington
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Marian Fiske, R.N., Chicago
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Don Paull, Ph.D., Chicago
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Fred Z. White, M.D., Chillicothe

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

160 North LaSalle Street, Room 1700, Chicago 60601
One North Old State Capitol Plaza, Springfield 62706
Gregory L. Coler, *Director*

Director's Office
Iris Slack, Deputy Director for Policy and Plans
Gordon Johnson, Deputy Director for Program Operations
Thomas Walsh, Deputy Director for Management and Budget
Michael Tristano, Deputy Director for Child Protection
Donald H. Schlosser, Chief of Communication/Community Relations
Marian Barnes, Chief Legal Counsel
Bruce Rubenstein, Legislative Liaison
Robert Antrim, Acting Chief of Internal Audits
Paul Freedlund, Special Assistant to the Director

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Thomas Ward, Region 1B Administrator, Peoria
Les Townsend, Region 2A Administrator, Aurora
Gordon Johnson, Region 2B Administrator, Chicago
William Gillespie, Region 3A Administrator, Springfield
Willis Hartman, Region 3B Administrator, Champaign
Anthony Jenkins, Region 4 Administrator, East St. Louis
Gene Ruehmkorff, Region 5 Administrator, Marion

Advisory Councils
DCFS Advisory Council, John Madden, Chairperson
Statewide Citizen's Committee on Child Abuse and Neglect, Nancy Peterson, Chairperson
Statewide Day Care Advisory Committee, Mae Husband, Chairperson

DEPARTMENT OF CORRECTIONS

160 N. LaSalle
Chicago, IL 60601
(312) 793-2955
1301 Concordia Court
Springfield, IL 62702
(217) 522-2666
Michael P. Lane, *Director*

Leo Meyer, Deputy Director-Adult Institutions
James R. Irving, Deputy Director-Juvenile Division
Thomas Hutchison, Executive Assistant to the Director
Anthony M. Scillia, Deputy Director-Community Services
Jerry Stepaniak, Deputy Director-Bureau of Administrative Services
Dr. William Craine, Deputy Director-Bureau of Employee and Inmate Services
Robert H. Klemm, Deputy Director-Bureau of Inspections and Audits
Laurel Rans, Deputy Director-Bureau of Policy Development
Samuel J. Sublett, Accreditation Manager
Nic Howell, Public Information Officer
Marie Hall, Health Services Administrator

Programs: 1) To develop and maintain reception and evaluation units for the purpose of analyzing the custody and rehabilitation needs of juvenile and adult offenders committed to it and to assign such persons to institutions and programs under its control or transfer them to other appropriate agencies; 2) to develop and maintain programs of control, rehabilitation and employment of committed persons within its institutions; 3) to establish a system of release, supervision and guidance of committed persons in the community; 4) to maintain records of persons committed to it and to establish programs of research, statistics and planning; 5) to investigate the grievances of any person committed to the agency and to inquire into any alleged misconduct by employees; and 6) to cooperate with other departments and agencies and with local communities for the development of standards and programs for better correctional services within the State.

DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES

401 S. Spring St., Springfield, 62706
160 N. La Salle St., Chicago, 60601
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Roalda J. Alderman, Associate Director for Alcoholism
Patricia Barger, Ph.D., Associate Director for Mental Illness
Richard Blanton, Ph.D., Associate Director for Developmental Disabilities
John P. Harcourt, Jr., Associate Director for Support Services

Office of the Director

Russell Blaauw, Legislative Liaison
Douglas Carey, Director of Communications
Maureen D. Mudron, General Counsel
John Ryan, Special Assistant
David B. Thomas, Chief Auditor
Dorothy Ackman, Administrative Assistant
Harriett Mitchell, Administrative Assistant

Director's Executive Council Members and Regional Administrators

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Patricia Barger, Ph.D., Associate Director for Mental Illness
Richard Blanton, Ph.D., Associate Director for Developmental Disabilities
John P. Harcourt, Jr., Associate Director for Support Services
Douglas Carey, Director of Communications
Raymond Stroh, Manager, Health Care Division, Personnel
Maureen D. Mudron, General Counsel
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Kenneth R. Swiatek, Ph.D., Illinois Institute for Developmental Disabilities
Jack Weinberg, M.D., Illinois State Psychiatric Institute
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James Dalzell, Region 1-B Administrator, Peoria
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Arthur Dykstra, Jr., Region 2 Developmental Disabilities Administrator, Tinley Park
Ugo Formigoni, Region 3-A Administrator, Springfield
J. Gregory Langan, Ed.D., Region 3-B Administrator, Champaign
Joseph Gruber, Ph.D., Region 4 Administrator, Alton
Ronald G. Bittle, Ph.D., Region 5 Administrator, Anna

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DEPARTMENT OF PUBLIC AID

316 South 2nd St., Springfield, 62701
Jeffrey C. Miller, *Director*

The Illinois Department of Public Aid administers the federally aided public assistance programs: Aid to Families with Dependent Children; Medical Assistance; and provides supplemental financial grants to eligible aged, blind, or disabled persons. In addition, the department allocates state funds to qualified and requesting governmental units for the administration of General Assistance; and in cooperation with the U.S. Department of Agriculture, administers the Food Stamp program.

Administrative Staff

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DEPARTMENT OF PUBLIC HEALTH

535 West Jefferson St., Springfield 62706

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(Allied with Public Health Operations)

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Welland Hause, M.D., Decatur
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Warren J. Brodine, Crete
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Dept. of Mental Health and Developmental Disabilities

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Hugh Rohrer, M.D., Peoria
Madeline Ruekberg, Evanston
Geraldine Stroka, Oak Park
Marie Walsh, R.N., Glenview

NON-STATUTORY BOARDS
(Allied with Public Health Operations)

Committee for Revision of the Rules and Regulations for the Control of Communicable Diseases

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H. H. Rohrer, M.D., M.P.H., Peoria
Daniel J. Pachman, M.D., Chicago
J. V. Johnson, D.V.M., M.P.H., Woodstock
Shelley S. Sansbury, Jr., Flora
Karen L. Scott, M.D., M.P.H., Maywood
Chlao L. Heinichen, R.N., M.P.H.,Wheaton
Bernard J. Turnock, M.D., M.P.H., Springfield, *staff consultant*

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Edward F. Lis, M.D., Springfield
Reuben Matalon, M.D., Chicago
Margaret E. O'Flynn, M.D., Chicago
Daniel J. Pachman, M.D., Chicago
Julio Pardo, M.D., Springfield
Eugene Pergament, M.D., Ph.D., Chicago
Ira M. Rosenthal, M.D., Chicago
Parvin Justice, Ph.D., Chicago
Paul Wong, M.D., Chicago
Robert T. Martinek, Ph.D., Chicago
Mindy Pollack, Chicago
Richard Hillman, M.D., St. Louis
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Advisory Committee For Perinatal Health

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Bruce A. Work, Jr., M.D., Wilmette
Rosita Pildes, M.D., Evanston
John J. Boehm, M.D., Chicago
Craig L. Anderson, M.D., Burr Ridge
William R. Hamilton, M.D., Murphysboro
Darrell E. Statzer, M.D., Decatur
John J. McLaughlin, M.D., Joliet
Carl F. Neuhoff, M.D., Peoria
Ann McCormick, Lincolnwood
Barbara Rohrer, Peoria
James M. Brophy, Highland*
Harlan Newkirk, Lansing
*Appointment confirmation pending

Sharon Patchak, Oak Park
Marian Thompson, Melrose Park
James P. Paulissen, M.D., Chicago
Virginia Hill, Springfield
Leisa Harper, A.C.S.W., Springfield
Laura Landrum, Chicago

State Emergency Medical Services Council

Jeanette A. McCammon, Peoria
John R. Lumpkin, M.D., Chicago
Joan E. Cummings, M.D., Glen Ellyn
John M. Holland, M.D., Springfield
Joseph Winterhalter, M.D., Jacksonville
Joyce M. Green, R.N., Aurora
Fred W. DeBow, Palos Park
Lanson W. Russell, Peotone
John W. Daley, M.D., South Holland
Louis B. Oine, Elgin
George Jerdan, Mattoon
Robert L. Harris, Olympia Fields
Virginia Ballarino, Chicago
Keith Smith, Lansing

Statewide Diabetes Advisory Council

Francis S. Agnoli, M.D., Hinsdale
Nancy Drake, Springfield
Anthony P. Ferracane, Harvey
Norbert Freinkel, M.D., Chicago
Edward Holland, M.D., Decatur
Robert Jackson, East Peoria
Sheila Lyne, R.S.M., Chicago
Marilyn Meyer, R.N., Effingham
Arthur Rubenstein, M.D., Chicago
Sister Paulette O'Connell, Chicago
Norman Soler, M.D., Ph.D., Springfield
Donna Stoner, Decatur
Stephen A. Weinberg, D.P.M., Buffalo Grove
Jerry Woolley, Chicago

Board of Public Health Advisors

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Dental Student Grant Act Advisory Committee

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Kathleen B. Fralish, Ph.D., Carbondale
Mrs. Verlene Mullens, Hopkins Park
Wilbur T. Reece, D.D.S., Springfield

POISON CONTROL CENTERS IN ILLINOIS

For information contact:
Division of Emergency Medical Services & Highway Safety
Illinois Department of Public Health
525 W. Jefferson
Springfield, 62761
Phone: (217) 785-2080

APPROVED RENAL DIALYSIS FACILITIES, CENTERS AND DIRECTORS

Illinois Department of Public Health

Division of Disease Control

For information contact:
Mrs. Mary Mahoney—Coordinator Direct Services Programs
Illinois Department of Public Health
Room 150, 535 West Jefferson Street, Springfield 62761
Phone (217) 782-3303

DEPARTMENT OF REGISTRATION AND EDUCATION

320 W. Washington Street, Springfield 62786
17 N. State Street, Chicago 60602
Gary L. Clayton, *Director*
Glen D. Crick, *Deputy Director/Statewide Enforcement*
John Dreiske, *Deputy Director/Licensing and Testing*
Edward F. Bruno, *Assistant Deputy Director/Regulatory*
Charles T. McHugh, M.D., *Medical Coordinator*
Louis R. Vitullo, *Chief of Medical Investigations*

The department is primarily concerned with the registration, licensing and enforcement of 30 laws governing the different professions, trades and occupations, including the Medical Practice Act.

The Medical Examining Committee appointed by the director of the Department operates within the framework of the act and is charged with the responsibility of supervising examinations for licensure and making recommendations to

the Director to grant or refuse to grant licenses. The Medical Disciplinary Board, appointed by the Governor, hears complaints for revocation and suspension of licenses and recommends disciplinary action to the Director.

Medical Examining Committee

David S. Fox, M.D., Chicago, *Acting Chairperson*
Paul Tullio, D.C., Glen Ellyn, *Secretary*
Robert Behmer, M.D., Rockford
Kenneth G. Eggen, M.D., Chicago
Larry S. Patton, D.O., Morton
(Two vacancies)

Medical Disciplinary Board

James B. Williams, M.D., Chicago, *Chairman*
John Gregorio, M.D., River Forest, *Vice Chairman*
Helen R. Beiser, M.D., Chicago, *Secretary*
Sam Brinkley, D.C., Alton
George Caleel, D.O., Chicago
Willard C. Scrivner, M.D., Belleville
(One vacancy)

MEDICAL PRACTICE ACT

Service on medical committees—Exemption from civil liability. § 2b. While serving upon any Medical Utilization Committee, Medical Review Committee, Patient Care Audit Committee, Medical Care Evaluation Committee, Quality Review Committee, Credential Committee, Peer Review Committee or any other committee whose purpose, directly or indirectly, is internal quality control or medical study to reduce morbidity or mortality, or for improving patient care within a hospital duly licensed under the Hospital Licensing Act, or the improving or benefiting of patient care and treatment whether within a hospital or not, or for the purpose of professional discipline, any person serving on such committee, and any person providing service to such committees shall not be liable for civil damages as a result of his acts, omissions, decisions, or any other conduct in connection with his duties on such committees, except those involving willful or wanton misconduct. *Amended by P.A. 79-1434 § 7, eff. Sept. 19, 1976; P.A. 80-771, § 3, eff. Oct. 1, 1977.*

Practice by person licensed in another state pending examination. § 2c.

This act does not prohibit the practice of medicine by a person who is licensed to practice medicine in all of its branches in any other state of the United States or the District of Columbia who has applied in writing to the Department, in form and substance satisfactory to the Department, for a license to practice medicine in all of its branches and has complied with all of the provisions of Section 13, except the passing of an examination which may be given under Section 13, until:

(a) the expiration of 6 months after the filing of such written application, or

(b) the decision of the Department that the applicant has failed to pass an examination within 6 months or failed without an approved excuse to take an examination conducted within 6 months by the Department, or

(c) the withdrawal of the application. *(Added by Act approved July 26, 1971)*

Dispensing drugs or medicine—Label.] § 2d.

Any person licensed under this act who dispenses any drug or medicine shall dispense such drug or medicine in good faith and shall affix to the box, bottle, vessel or package containing the same a label indicating (a) the date on which such drug or medicine is dispensed; (b) the name of the patient; (c) the last name of the person dispensing such drug or medicine; (d) the directions for use thereof; and (e) the proprietary name or names or, if there is none, the established name or names of the drug or medicine, the dosage and quantity, except as otherwise authorized by regulation of the Department of Registration and Education. This Section shall not apply to drugs or medicines in a package which bears a label of the manufacturer containing information describing its contents which is in compliance with requirements of the Federal Food, Drug and Cosmetic Act and the Illinois Food, Drug and Cosmetic Act and which is dispensed without consideration by a practitioner licensed under this Act. "Drug" and "medicine" have the meaning ascribed to them in the "Pharmacy Practice Act," approved July 11, 1955, as now or hereafter amended; "good faith" has the meaning ascribed to it in subsection (v) of Section 102 of the "Illinois Controlled Substances Act," approved August 16, 1971, as amended. *Formerly § 2c. Renumbered § 2d by P.A. 77-1849, § 3, eff. July 1, 1972. Amended by PA 82-162, eff. Jan. 1, 1982.*

§ 5. *Minimum standards of professional education.* Except as provided in Section 9a of this Act, the minimum standards of professional education to be enforced by the department in conducting examinations and issuing licenses shall be as follows:

1. *Practice of Medicine.* For the practice of medicine in all of its branches:

(a) For an applicant who is a graduate of a medical college before the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to graduation a 4 years' course of instruction of not less than 9 months each, in such medical college, or its equivalent, the time elapsing between the beginning of the first year and the ending of the fourth year having been not less than 40 months, and which was reputable and in good standing in the judgment of the department; and prior to taking such examination said applicant must present proof that he has completed a 4 years' course of instruction in a high school or its equivalent as determined by an examination conducted by the department.

(b) For an applicant who is a graduate of a medical college after the passage of this Act, that such medical college at the time of his graduation required as a prerequisite to admission thereto 2 years' course of instruction in a college of liberal arts, or its equivalent, or in such medical college, and a course of instruction in a medical college in the treatment of human ailments, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, and in addition thereto, a course of clinical training of not less than 12 months in a hospital, such college of liberal arts, medical college and hospital having been reputable and in good standing in the judg-

ment of the department. The time requirement of not less than 132 weeks within a period of 35 months, set forth above, may be reduced by the department upon recommendation of the Dean of the medical school in the case of programs involving students with advanced standing.

(c) For an applicant who is a graduate of a medical college or school in another country; that such applicant was a resident of this State for a period of five years prior to matriculating in such medical college or school; that such applicant completed a required course of instruction in the treatment of human ailments as offered by such college or school of medicine, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of three years' course of instruction in an accredited college of liberal arts or its equivalent; that such applicant submit an application to an Illinois medical school and submit to such testing procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school, to determine equivalency of education compared to state norms, such testing could be utilized in placement of such applicant at a level appropriate to educational achievement; that such applicant may be placed by an Illinois medical school into the appropriate level of medical school, thru internship training, provided that applicant agrees to pay, either by a scholarship or some other personal means, such tuition and fees necessary to complete medical education, and provided that such applicant signs a statement in a form to be determined by the Department that upon successful completion of all licensure requirements applicant intends to practice medicine in this State. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicant shall be eligible for award of an M.D. degree and examination and licensing for the practice of medicine in all of its branches as provided in this act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

(d) Until September 1, 1988, for an applicant who has studied medicine at a medical college or school located outside the United States; that such applicant has completed all of the formal requirements of a foreign medical school except internship and/or social service, which course shall have been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months; that such applicant has completed a minimum of 3 years' course of instruction in an accredited college of liberal arts or its equivalent; that such an applicant has submitted an application to a medical school recognized by the Department and submitted to such evaluation procedures, including use of nationally recognized medical student tests and/or tests devised by the individual medical school and that such applicant has satisfactorily completed one academic year of supervised clinical training under the direction of such medical school; and, after completion of said academic year of supervised clinical training, that such applicant has satisfactorily completed twelve months of post graduate training in an approved hospital having been reputable and in good standing in the judgment of the Department; and provided that such applicant sign a statement and a form, to be determined by the Department, that upon successful completion of all license requirements, applicant intends to practice medicine in this state. Upon completion of such course or activity of didactic and medical training as specified by an accepting medical school, applicants shall be eligible for examination and licensing for the practice of medicine in all of its branches as provided in this Act and upon payment of the fee provided in paragraph (a) of sub-section 4 of Section 4 of this Act.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of the completion of any foreign internship and/or social service requirements, and no such requirements shall be a condition of licensure as a physician in this State.

Until September 1, 1988, satisfaction of the requirements of this sub-section shall be in lieu of certification by the Educational Council for Foreign Medical Graduates, and such certification shall not be a condition of licensure as a physician in this state for candidates who have completed the requirements of this sub-section.

Until September 1, 1988, no hospital licensed by the State, or operated by the State or political subdivision thereof, or which receive State financial assistance, directly or indirectly, shall require an individual who at the time of his enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirement other than those contained in this sub-section prior to commencing an internship or residency.

Until September 1, 1988, a document granted by a medical school located outside the United States which certifies completion of all of the formal training requirements of such foreign medical school except internship and/or social service; and satisfactory completion of the examination and academic year of supervised clinical training at a medical school recognized by the Department referred to in this sub-section shall be deemed the equivalent of the degree of Doctor of Medicine for purposes of licensure and practice as a physician in this State and shall possess all the rights and privileges thereof.

The Illinois Board of Higher Education may make grants to Illinois Medical Schools, public and private, for each applicant who commences his academic year of supervised clinical training under the direction of said medical school. Preference shall be given in the award of these grants to Illinois residents. The Illinois Board of Higher Education shall by regulation adopt reasonable guidelines for the distribution of funds authorized by this Act. *(Added by Act approved Sept. 7, 1974).*

2. *Treating human ailments without drugs or medicines and without operative surgery.* For the practice of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery:

(a) For an applicant who was a resident student and who is a graduate before July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments, which he specifically designated in his application as the one he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to graduation a 3 years' course of instruction of not less than 6 months each, the time elapsing between the beginning of the first year and the ending of the third year having been not less than 22 months, and which are reputable and in good standing in the judgment of the department and prior to taking the examination the applicant must present proof that he has completed a 4 years' course of instruction in high school, or its equivalent, as determined by an examination conducted by the department.

(b) For an applicant who was a resident student and who is a graduate after July 1, 1926, of a professional school, college or institution which taught the system or method of treating human ailments which he specifically designated in his application as the one which he would undertake to practice, that such school, college or institution at the time of his graduation required as a prerequisite to admission thereto a 4 years' course of instruction in a high school, and as a prerequisite to graduation therefrom a course of instruction in the treatment of human ailments, of not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months except that as to students matriculating or entering upon a course of study of any system or method of treating human ailments without the use of drugs or medicines and without operative surgery during the years 1940, 1941, 1942, 1943, 1944, 1945, 1946 and 1947, the said elapsed time shall be not less than 32 months, such high school and such school, college, institution having been reputable and in good standing in the judgment of the department.

(c) For an applicant who is a matriculant in a chiropractic college after September 1, 1969, that such applicant shall be

required as a prerequisite for admission to examine for licensure, to complete a 2 years' course of instruction in a liberal arts college or its equivalent, and a course of instruction in a chiropractic college in the treatment of human ailments, such course as a prerequisite to graduation therefrom having been not less than 132 weeks in duration and shall have been completed within a period of not less than 35 months, such college of liberal arts and chiropractic college having been reputable and in good standing in the judgment of the Department.

(d) For an applicant who is a graduate of a United States chiropractic college after the effective date of this amendatory Act of 1981, the college of the applicant must be fully accredited by the Commission on Accreditation of the Council on Chiropractic Education or its successor. Such graduates shall be considered to have met the minimum requirements which shall be in addition to those requirements set forth in the rules and regulations promulgated by the Department of Registration and Education.

(e) For an applicant who is a graduate of a chiropractic college in another country; that such chiropractic college be equivalent to the standards of education as set forth for U.S. chiropractic colleges.

3. *Midwifery.* For the practice of midwifery: That he be a graduate of a college of midwifery which requires as a prerequisite to admission thereto, a one year's course of instruction in a high school or its equivalent, and required as a prerequisite to graduation, a one year's course in such college of midwifery, the time actually spent under instruction in such college of midwifery to have been not less than 12 months; such high school or equivalent school, and such college of midwifery having been in good standing in the judgment of the department.

Without prejudice to licenses heretofore issued under this section, no further licenses shall be issued under this section after the effective date of this amendment.

(Amended by PA 80-368, eff. Oct. 1, 1977. Amended by PA 82-276, eff. Aug. 19, 1981.)

Continuing Education

Continuing education—Recommendations by Examining Committee

§ 5.1. The Department, based on the written recommendation of the Examining Committee, shall promulgate mandatory requirements of continuing education for persons licensed pursuant to this Act. In establishing such recommendations, the Committee shall:

(1) Develop practical and meaningful criteria for defining and describing continuing education requirements which meet, but are not limited to, the following specifications:
 (a) Readily available to all practicing physicians in Illinois without undue commitment of time away from practice and expense on the part of the practitioner.
 (b) Compatible with existing requirements of licensing agencies in other states.
 (c) Compatible with the requirements of medical specialty boards for recertification of specialty status.
 (d) Compatible with the continuing education requirements developed by national medical specialty societies.
 (e) Compatible with continuing education programs and requirements that are developed in federally mandated peer review programs and as a part of Professional Standards Review Organizations.
 (f) Provides for differing requirements for licensees engaged in other than direct patient care (example: educators, researchers and those engaged in medical administration).
 (g) Provides for compatible requirements for licensees in the federal uniformed services, those engaged in formal residency and fellowship training programs, and licensees operating under hospital permit licensure.

(2) Conceive, develop and evaluate procedures, materials and systems to carry out the administrative requirements of this legislation which include, but are not limited to, the following:
 (a) Procedures for prompt and fair evaluation of reports of educational achievement submitted by licensees.
 (b) Requirements and position descriptions for personnel engaged in reviewing and evaluating reports and continuing educational achievements submitted by licensees.
 (c) A data recording system for gathering, analyzing, storing and retrieving information on individual licensee educational accomplishments.
 (d) Provision for licensee to appeal adverse actions and temporary exemptions from requirements under unusual circumstances.
 (e) Exemption from legal prosecution of all persons responsible for action taken under the program.
 (f) Establishment of realistic budgeting and cost requirements for the personnel, and operational funds necessary to plan, develop and operate the program.
 (g) Procedures for surveying and evaluating the effectiveness of the program.
 (h) Orderly procedures for adequate notice to licensee of pending action that may result in non-renewal of license, including provisions for consultation and assistance in time for him to meet the requirements of this Act.
 (i) Provision for an extension of license during any renewal period when a compliance audit of continuing education credits of any person licensed under this Act is undertaken. Such extension shall be for a period not to exceed 3 months within which such compliance audit shall be completed. Orderly procedures shall be developed by the Department for adequate notification and methods of determining compliance with any audit undertaken by the Department.
 (j) Orderly procedures for establishing requirements for reinstatement of any license not renewed because the holder of such license has failed to demonstrate compliance with the continuing education requirements of the Rules and Regulations promulgated for the administration of this Section.

(3) Develop adequate protection for information about licensee participation in continuing education as it pertains to all aspects of practice liability and the licensee's public image and his relationships with individual patients.

(4) Develop an advisory panel for each category of licensee to advise and assist the department in developing and application of continuing education criteria, administrative procedures and policy.

(5) Develop procedures for assuring that the educational opportunities available to licensees for fulfilling the requirements of this act are of appropriate scope, variety, depth and of high quality.

The Department shall enforce these requirements; however, the Department shall be empowered to waive enforcement of these requirements in localities where it is demonstrated that the absence of opportunities for such education would interfere with the adequacy of medical services in that locality. *Amended by P.A. 80-1203, § 1, eff. June 30, 1978.*

Section 14. (A) *Renewal.* The expiration date and renewal period for each certificate of registration issued under this Act, shall be set by rule. The holder of a certificate of registration may renew such certificate during the month preceding the examination date thereof by paying the required fee. *(Amended by PA 82-149, eff. Jan. 1, 1982.)*

REVOCATION OR SUSPENSION OF LICENSE, CERTIFICATE, OR PERMIT—PROBATION OR OTHER DISCIPLINARY ACTION

§ 16. The Department may revoke, suspend, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to the license, certificate or state hospital permit of any person issued under this Act or under any other Act in this State to practice medicine, to practice the treatment of human ailments in any manner or to practice midwifery, or may refuse to grant a license, certificate or state hospital permit under this Act or may grant a license, certificate or State hospital permit on a probationary status subject to the limitations of the probation, and may cause any license or certificate which has been the subject of formal disciplinary procedure to be marked accordingly on the records of any county clerk upon any of the following grounds:

1. Performance of an elective abortion in any place, locale, facility, or institution other than:

(a) a facility licensed pursuant to the "Ambulatory Surgical Treatment Center Act" as heretofore or hereafter amended;

(b) an institution licensed pursuant to "An Act relating to the inspection, supervision, licensing, and regulation of hospitals" approved July 1, 1953, as heretofore or hereafter amended; or

(c) an ambulatory surgical treatment center or hospitalization or care facility maintained by the State or any agency thereof, where such department or agency has authority under law to establish and enforce standards for the ambulatory surgical treatment centers, hospitalization, or care facilities under its management and control; or

(d) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by the Federal Government; or

(e) Ambulatory surgical treatment centers, hospitalization or care facilities maintained by any university or college established under the laws of this State and supported principally by public funds raised by taxation;

2. Performance of an abortion procedure in a wilful and wanton manner on a woman who was not pregnant at the time the abortion procedure was performed.

3. Conviction in this or another State of any crime which is a felony under the laws of this State or conviction of a felony in a federal court, unless such person demonstrates to the Department that he has been sufficiently rehabilitated to warrant the public trust;

4. Gross or repeated malpractice resulting in serious injury or death of a patient;

5. Engaging in dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public;

6. Obtaining a fee, either directly or indirectly, either in money or in the form of anything else of value or in the form of a financial profit as personal compensation, or as compensation, charge, profit or gain for an employer or for any other person or persons, on the fraudulent representation that a manifestly incurable condition of sickness, disease or injury of any person can be permanently cured;

7. Habitual intemperance in the use of ardent spirits, narcotics or stimulants to such an extent as to incapacitate for performance of professional duties;

8. Holding one's self out to treat human ailments under any name other than his own, or the personation of any other physician;

9. Employment of fraud, deception or any unlawful means in applying for or securing a license, certificate, or state hospital permit to practice the treatment of human ailments in any manner, to practice midwifery or in passing an examination therefor, or wilful and fraudulent violation of the rules and regulations of the department governing examinations;

10. Holding one's self out to treat human ailments by making false statements, or by specifically designating any disease, or group of diseases and making false claims of one's skill, or of the efficacy or value of one's medicine, treatment or remedy therefor;

11. Professional connection or association with, or lending one's name to, another for the illegal practice by another of the treatment of human ailments as a business, or professional connection or association with any person, firm, or corporation holding himself, themselves, or itself out in any manner contrary to this Act;

12. Revocation or suspension of a medical license in a sister state;

13. A violation of any provision of this Act or of the rules and regulations formulated for the administration of this Act;

14. Directly or indirectly giving to or receiving from any physician, person, firm or corporation any fee, commission, rebate or other form of compensation for any professional services not actually and personally rendered. Nothing contained in this subsection prohibits persons holding valid and current licenses under this Act from practicing medicine in partnership under a partnership agreement or in a corporation authorized by "The Medical Corporation Act", as now or hereafter amended, or as an association authorized by "The Professional Association Act" as now or hereafter amended, or under "The Professional Corporation Act" as now or hereafter amended, or from pooling, sharing, dividing or apportioning the fees and monies received by them or by the partnership, corporation or association in accordance with the partnership agreement or the policies of the Board of Directors of the corporation or association. Nothing contained in this subsection prohibits 2 or more corporations authorized by "The Medical Corporation Act", as now or hereafter amended, from forming a partnership or joint venture of such corporations, and providing medical, surgical and scientific research and knowledge by employees or these corporations if such employees are licensed under this Act, or from pooling, sharing, dividing, or apportioning the fees and monies received by the partnership or joint venture in accordance with the partnership or joint venture agreement. Nothing contained in this subsection shall abrogate the right of 2 or more persons holding valid and current licenses under this Act to receive adequate compensation for concurrently rendering professional services to a patient and divide a fee; provided, the patient has full knowledge of the division, and, provided, that the division is made in proportion to the services performed and responsibility assumed by each.

15. A finding by the Medical Disciplinary Board that the registrant after having his license placed on probationary status violated the terms of the probation.

16. Abandonment of a patient.

17. The use or prescription for use of narcotics or controlled substances (designated products) in any way other than for therapeutic purposes.

18. Promotion of the sale of drugs, devices, appliances or goods provided for a patient in such manner as to exploit the patient for financial gain of the physician.

19. Offering, undertaking or agreeing to cure or treat disease by a secret method, procedure, treatment or medicine, or the treating, operating or prescribing for any human condition by a method, means or procedure which the licensee refuses to divulge upon demand of the Department of Registration and Education.

20. Immoral conduct in practice as a physician, or repeated acts of gross misconduct.

21. Willfully making or filing false records or reports in his practice as a physician, including, but not limited to, false records to support claims against the medical assistance program of the Department of Public Aid under the Public Aid Code.

22. Willful omission to file or record, or willfully impeding the filing or recording or inducing another person to omit to file or record medical reports as required by law.

23. Solicitation of professional patronage by any corpo-

ration, agents or persons, or profiting from those representing themselves to be agents of the licensee.

24. Gross and willful and continued overcharging for professional services, including filing false statement for collection of fees for which services are not rendered, including, but not limited to, filing such false statements for collection of monies for services not rendered from the medical assistance program of the Department of Public Aid under the Public Aid Code.

25. Professional incompetence as manifested by poor standards of care or mental incompetency as declared by a court of competent jurisdiction.

26. Physical illness, including, but not limited to, deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill or safety.

All proceedings to suspend, revoke, place on probationary status, or take any other disciplinary action as the Department may deem proper with regard to a license or certificate on any of the foregoing grounds, except the ground numbered 9 (fraudulent grounds excepted) must be commenced within 3 years next after the conviction or commission of any of the acts described therein, except as otherwise provided by law; but the time during which the holder of the license or certificate was without the State of Illinois shall not be included within the 3 years.

The entry of any order or judgment by any circuit court establishing that any person holding a license or certificate under this Act is a person in need of mental treatment operates as a suspension of that license or certificate. That person may resume his practice only upon a finding by the Medical Disciplinary Board that he has been determined to be recovered from mental illness by the court and upon the Board's recommendation that he be permitted to resume his practice.
Amended by P.A. 81-1136, § 1, eff. July 1, 1980; PA 82-185, eff. August 14, 1981; P.A 82-263, eff. August 19, 1981.

Advertising

§ 16.01. Any person licensed under this Act may advertise the availability of professional services in the public media or on the premises where such professional services are rendered. Such advertising shall be limited to the following information:

(1) Publication of the person's name, title, office hours, address and telephone number;

(2) Information pertaining to his areas of specialization, including appropriate board certification or limitation of professional practice;

(3) Information on usual and customary fees for routine professional services offered which such information shall include notification that fees may be adjusted due to complications or unforeseen circumstances;

(4) Announcement of the opening of, change of, absence from, or return to business;

(5) Announcement of additions to or deletions from professional licensed staff;

(6) The issuance of business or appointment cards.

It is unlawful for any person licensed under this Act to use testimonials or claims of superior quality of care to entice the public. It shall be unlawful to advertise fee comparisons of available services with those of other persons licensed under this Act.

This Act does not authorize the advertising of professional services which the offeror of such services is not licensed to render. Nor shall the advertiser use statements which contain false, fraudulent, deceptive or misleading material or guarantees of success, statements which play upon the vanity or fears of the public, or statements which promote or produce unfair competition.
Amended by P.A. 81-1136, § 1, eff. July 1, 1980.

Medical Disciplinary Board

Illinois State Medical Disciplinary Board. § 16.02.

There is hereby created the Illinois State Medical Disciplinary Board, (hereinafter referred to as the "Board"). The Board shall consist of 7 members, appointed by the Governor by and with advice and consent of the Senate. All shall be residents of the State, not more than 4 of whom shall be members of the same political party. Five members shall be physicians licensed to practice medicine in all of its branches in Illinois. One member shall be an Illinois physician possessing the degree of doctor of osteopathy. One member shall be a person licensed in Illinois and possessing a chiropractor's degree.

a. Of the members of the Board first appointed, two shall be appointed for terms of 2 years, two shall be appointed for terms of 3 years, and three shall be appointed for terms of 4 years. Upon the expiration of the term of any member, his successor shall be appointed for a term of four years by the Governor by and with the advice and consent of the Senate. The Governor shall fill any vacancy for the remainder of the unexpired term by and with the advice and consent of the Senate. Upon recommendation of the Board, any member of the Board may be removed by the Governor for misfeasance, malfeasance, or willful neglect of duty after notice and a public hearing unless such notice and hearing shall be expressly waived in writing. Each member shall serve on the Board until his successor is appointed and qualified. No member of the Board shall serve more than two consecutive four year terms.
In making appointments the Governor shall attempt to insure that the various social and geographic regions of the State of Illinois are properly represented. In making the designation of persons to act for the several professions represented on the Board, the Governor shall give due consideration to recommendations by members of the respective professions and by organizations therein.

b. The Board shall annually elect one of its members as chairman, one as vice chairman and one as secretary. No officer shall be elected more than twice in succession to the same office. Each officer shall serve until his successor has been elected and qualified.

c. The secretary shall keep a record of the proceedings of the Board and shall be custodian of all books, documents and papers filed with the Board, including the minute book or journal of the Board. The secretary or other persons authorized by the Board may cause copies to be made of all minutes and other records and documents of the Board and may give certificates of the Board to the effect that such copies are true copies, and all persons dealing with the Board may rely upon such certificates.

d. Four members of the Board shall constitute a quorum. A vacancy in the membership of the Board shall not impair the right of a quorum to exercise all the rights and perform all the duties of the Board. Any action taken by the Board under this Act may be authorized by resolution at any regular or special meeting and each such resolution shall take effect immediately. The Board shall meet at least quarterly. The Board is empowered to adopt all rules and regulations necessary and incident to the powers granted to it under this Act.

e. Each member, and member-officer, of the Board shall receive a per-diem stipend as the Director of the Department of Registration and Education, hereinafter referred to as the Director, shall determine. Each member shall be paid his necessary expenses while engaged in the performance of his duties.

f. The Director shall, in conformity with the "Personnel Code," as now or hereafter amended, select a medical coordinator, who shall not be a member of the Board. The medical coordinator shall be a physician licensed to practice medicine in all of its branches, and the Director shall set his rate of compensation. The medical coordinator shall

be the chief enforcement officer of the Medical Practice Act and shall serve at the will of the Board.

The Director shall employ, in conformity with the Personnel Code, not less than one (1) full time investigator for every 5000 physicians licensed to practice medicine in the State. Each investigator shall be a college graduate with at least two years' investigative experience or one year advanced medical education. Upon the written request of the Board, the Director shall employ, in conformity with the Personnel Code, such other professional, technical, investigative, and clerical help, either as a full or part-time basis as the Board deems necessary for the proper performance of its duties. All employees of the Board shall be directed by, and answerable to, the Board with respect to their duties and functions.

g. Upon the specific request of the Board, signed by either the chairman, vice chairman, or medical coordinator of the Board, the Bureau of Drug Compliance, the Office of Professional Supervision of the Department of Registration and Education, the Illinois Law Enforcement Commission, the Illinois Bureau of Investigation, the Illinois Legislative Investigating Commission shall:
 (1) Make available any and all information that they shall have in their possession regarding a particular case then under investigation by the Board.
h. Members of the Board shall be immune from suit in any action based upon any disciplinary proceedings of other acts performed in good faith as members of the Board.

Added by P.A. 79-1130, § 1, eff. Nov. 21, 1975.

Medical Examining Committee

Section 16.03. There is hereby created a Medical Practice Examining Committee (hereinafter referred to as the "Committee"). The Committee shall be composed of 7 persons, 5 of whom shall be reputable physicians licensed to practice medicine and surgery in this State possessing the degree of doctor of medicine, one person shall be a reputable licensed physician possessing the degree of doctor of osteopathy, and one person shall be a reputable licensed physician possessing the degree of doctor of chiropractic. Of the 5 members holding the degree of doctor of medicine, one shall be a full-time teacher of professional rank in one of the clinical departments of the University of Illinois College of Medicine, or of the Southern Illinois University School of Medicine. For the purpose of preparing questions and rating papers on practice peculiar to any school, graduates of which may be candidates for registration or license, the Director may designate additional examiners whenever occasion may require.

The Committee shall receive the same compensation as the members of the Illinois State Medical Disciplinary Board, which compensation shall be paid out of the Illinois State Medical Disciplinary Fund.

(Added by PA 82-633, eff. Sept. 24, 1981.)

Suspension or revocation of license or certificate—Investigation—Notice—Hearing.] § *17.01.* Upon the motion of either the Department or the Board or upon the verified complaint in writing of any person setting forth facts which if proven would constitute grounds for suspension or revocation under Section 16 of this Act, the Board shall investigate the actions of any person, so accused who holds or represents that he holds a license or certificate. Such person is hereinafter called the accused.

The Department shall, before suspending, revoking, placing on probationary status, or taking any other disciplinary action as the Department may deem proper with regard to any license or certificate, at least 30 days prior to the date set for the hearing, notify the accused in writing of any charges made and the time and place for a hearing of the charges before the Board, direct him to file his written answer thereto to the Board under oath within 20 days after the service on him of such notice and inform him that if he fails to file such answer default will be taken against him and his license or certificate may be suspended, revoked, placed on probationary status, or have other disciplinary action, including limiting the scope, nature or extent of his practice, as the Department may deem proper taken with regard thereto.

Where a physician has been found, upon complaint and investigation of the Department, and after hearing, to have performed an abortion procedure in a wilful and wanton manner upon a woman who was not pregnant at the time such abortion procedure was performed, the Department shall automatically revoke the license of such physician to practice medicine in Illinois.

Such written notice and any notice in such proceedings thereafter may be served by delivery of the same personally to the accused person, or by mailing the same by registered or certified mail to the address last theretofore specified by the accused in his last notification to the Department.

Amended by P.A. 81-302, § 1, eff. Jan. 1, 1980; PA 82-263, eff. August 19, 1981.

Hearings by board—Continuance—Failure to file answer—Disciplinary action—Temporary suspension of license without hearing.] § *17.02.* At the time and place fixed in the notice, the Board provided for in this Act shall proceed to hear the charges and both the accused person and the complainant shall be accorded ample opportunity to present in person, or by counsel, such statements, testimony, evidence and argument as may be pertinent to the charges or to any defense thereto. The Board may continue such hearing from time to time. If the Board is not sitting at the time and place fixed in the notice or at the time and place to which the hearing has been continued, the Department shall continue such hearing for a period not to exceed 30 days.

In case the accused person, after receiving notice, fails to file an answer, his license or certificate may in the discretion of the Director, having received first the recommendation of the Board, be suspended, revoked, placed on probationary status, or the Director may take whatever disciplinary action as he may deem proper, including limiting the scope, nature, or extent of said person's practice, without a hearing, if the act or acts charged constitute sufficient grounds for such action under this Act.

The Board has the authority to recommend to the Director that probation be granted or that other disciplinary action, including the limitation of the scope, nature or extent of a person's practice, be taken as it deems proper. If disciplinary action other than suspension or revocation is taken, the Board may recommend that the Director impose reasonable limitations and requirements upon the accused registrant to insure compliance with terms of the probation or other disciplinary action including, but not limited to, regular reporting by the accused to the Department of his actions, placing himself under the care of a qualified physician for treatment, or limiting his practice in such manner as the Director may require.

The Director may temporarily suspend the license of a physician without a hearing, simultaneously with the institution of proceedings for a hearing provided under this Section if the Director finds that evidence in his possession indicates that a physician's continuation in practice would constitute an immediate danger to the public. In the event that the Director suspends, temporarily, the license of a physician without a hearing, a hearing by the Board must be held within 15 days after such suspension has occurred.

Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Subpoena of witnesses—Administration of oath.] § *17.03* The Board or Department has power to subpoena and bring before it any person in this State and to take testimony either orally or by deposition, or both, with the same fees and mileage and in the same manner as is prescribed by law for judicial procedure in civil cases.

The Director, Assistant Director, Superintendent of Registration and any member of the Board each have power to

administer oaths at any hearing which the Board or Department is authorized by law to conduct.
Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Attendance of witnesses and production of books and papers.] § *17.04* Any circuit court upon the application of the accused person or complainant or of the Department or Board, may order the attendance of witnesses and the production of relevant books and papers before the Board in any hearing relative to the application for or refusal, recall, suspension or revocation of a license or certificate. The court may compel obedience to its order by proceedings for contempt.
Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Record of proceedings.] § *17.05* The Department, at its expense, shall provide a stenographer to take down the testimony and preserve a record of all proceedings at the hearing of any case wherein a license or certificate may be revoked, suspended, placed on probationary status, or other disciplinary action taken with regard thereto. The notice of hearing, complaint and all other documents in the nature of pleadings and written motions filed in the proceedings, the transcript of testimony, the report of the Committee and the orders of the Department constitute the record of such proceedings. The Department shall furnish a transcript of such record to any person interested in such hearing upon payment therefor of one dollar per page for each original transcript and 50¢ per page for each carbon copy thereof ordered with the original; except that the charge for any part of such transcript ordered and paid for previous to the writing of the original record thereof shall be 50¢ per page for each carbon copy.
Amended by P.A. 77-2829, § 34, eff. Dec. 22, 1972; P.A. 78-255, § 61, eff. Oct. 1, 1973.

Report of findings and recommendations—Motion for Rehearing—Certificate of order of revocation, suspension, or other disciplinary action.] § *17.06.* The Board shall present to the Director a written report of its findings and recommendations. A copy of such report shall be served upon the accused person, either personally or by registered or certified mail. Within 20 days after such service, the accused person may present to the Department his motion in writing for a rehearing, which written motion shall specify the particular ground therefor. If the accused person orders and pays for a transcript of the record as provided in Section 17.05, the time elapsing thereafter and before such transcript is ready for delivery to him shall not be counted as part of such 20 days.

At the expiration of the time allowed for filing a motion for rehearing the Director may take the action recommended by the Board. Upon the suspension, revocation, placement on probationary status, or the taking of any other disciplinary action, including the limiting of the scope, nature, or extent of one's practice, deemed proper by the department, with regard to the license, certificate or state hospital permit, the accused shall surrender his license or certificate to the Department, if ordered to do so by the Department, and upon his failure or refusal so to do, the Department may seize the same.

Each certificate of order of revocation, suspension, or other disciplinary action shall contain a brief, concise statement of the ground or grounds upon which the Department's action is based, as well as the specific terms and conditions of such action. This document shall be retained as a permanent record by the Board and the Director.

In those instances where an order of revocation, suspension, or other disciplinary action has been rendered by virtue of a physician's physical illness, including, but not limited to deterioration through the aging process, or loss of motor skill which results in a physician's inability to practice medicine with reasonable judgment, skill, or safety, the Department shall only permit this document, the the record of the hearing incident thereto, to be observed, inspected, viewed, or copied pursuant to court order.
Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Restoration of license or certificate.] § *17.07* At any time after the suspension, revocation, placing on probationary status, or taking disciplinary action with regard to any license or certificate, the Department may restore it to the accused person, or take any other action to reinstate the license to good standing, without examination, upon the written recommendation of the Board.
Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Review under Administrative Review Act—Venue.] § *17.08* All final administrative decisions of the Department are subject to judicial review pursuant to the provisions of the "Administrative Review Act", approved May 8, 1945, and all amendments and modifications thereof, and the rules adopted pursuant thereto. The term "administrative decision" is defined as in Section 1 of the "Administrative Review Act".

Such proceedings for judicial review shall be commenced in the Circuit Court of the County in which the party applying for review resides; but if such party is not a resident of this State, the venue shall be in Sangamon County.

The Department shall not be required to certify any record to the Court or file any answer in Court or otherwise appear in any Court in a Judicial review proceeding, unless there is filed in the Court with the complaint a receipt from the Department acknowledging payment of the costs of furnishing and certifying the record which costs shall be computed at the rate of 20 cents per page of such record. Exhibits shall be certified without cost. Failure on the part of the Plaintiff to file such receipt in Court shall be grounds for dismissal of the action. During the pendency and hearing of any and all Judicial proceedings incident to such disciplinary action the sanctions imposed upon the accused by the Department shall remain in full force and effect.
Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Order of revocation or suspension as prima facie evidence.] § *17.09* An order of revocation, suspension, placing the license on probationary status, or other formal disciplinary action as the Department may deem proper, or a certified copy thereof, over the seal of the Department and purporting to be signed by the Director, is prima facie proof that:

1. Such signature is the genuine signature of the Director;
2. The Director is duly appointed and qualified; and
3. The Board and the members thereof are qualified.

Such proof may be rebutted.
Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Action and report of board—Reasons of disagreement by Director—Necessity for exercise of powers—Re-examination or re-hearing.] § *17.10*

None of the disciplinary functions, powers and duties enumerated in this Act shall be exercised by the Department except upon the action and report in writing of the Board.

In all instances, under this Act, in which the Board has rendered a recommendation to the Director with respect to a particular physician, the Director shall, in the event that he disagrees with or takes action contrary to the recommendation of the Board, file with the Board and the Secretary of State his specific written reasons of disagreement with the Board. Such reasons shall be filed within 30 days of the occurrence of the Director's contrary position having been taken.

The action and report in writing of a majority of the Board designated is sufficient authority upon which the Director may act.

Whenever the Director is satisfied that substantial justice has not been done either in an examination, or in a formal disciplinary action, or refusal to restore a license or certificate, he may order a re-examination or re-hearing by the same or other examiners.
Amended by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Confidentiality of information received at hearings.] § *17.11* In all hearings conducted under this Act, information received, pursuant to law, relating to any information acquired by a physician in attending any patient in a professional character, necessary to enable him professionally to serve such patient, shall be deemed strictly confidential and shall only be made available either as part of the record of such hearing or otherwise; (1) when such record is required, in its entirety, for purposes of judicial review pursuant to this Act; or (2) upon the express, written consent of the patient, or in the case of his death or disability, of his personal representative.
Added by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Liability for disciplinary action without reasonable basis in fact.] § *17.12* In the event that the Department's order of revocation, suspension, placing the licensee on probationary status, or other order of formal disciplinary action is without any reasonable basis in fact of any kind, then the State of Illinois shall be liable to the injured physician for those special damages he has suffered as a direct result of such order.
Added by P.A. 79-1130, § 1, eff. Aug. 1, 1975.

Report of violations—Immunity from liability—Assistance in medical competency examinations—Hearing officers.] § *17.13* Any physician licensed under this Act, the Illinois State Medical Society, the Illinois Osteopathic Association, the Chiropractic Association, or any component societies of any of these three groups, and any other person, may report to the Board any information such physician, association, society, or person may have which appears to show that a physician is or may be in violation of any of the provisions of Section 16 of the Medical Practice Act. Any such physician, association, society or person, participating in good faith in the making of a report, under this Act, shall have immunity from any liability, civil, criminal, or that otherwise might result by reason of such actions. For the purpose of any proceedings, civil or criminal, the good faith of any such physician, association, society or persons shall be presumed. The Board may request the Illinois State Medical Society, the Illinois Osteopathic Association, or the Illinois Chiropractic Association both to assist the Board in preparing for or conducting any medical competency examination as the Board may deem appropriate. The Board shall retain and use such hearing officers as it deems necessary.
Amended by P.A. 80-965, § 1, eff. Sept. 22, 1977.

Punishment for doing certain acts without license.] § *24.* If any person holds himself out to the public as being engaged in the diagnosis or treatment of ailments of human beings; or suggests, recommends or prescribes any form of treatment for the palliation, relief or cure of any physical or mental ailment of any person with the intention of receiving therefore, either directly or indirectly, any fee, gift, or compensation whatsoever; or diagnosticates or attempts to diagnosticate, operate upon, profess to heal, prescribe for, or otherwise treat any ailment, or supposed ailment, of another; or maintains an office for examination or treatment of persons afflicted, or alleged or supposed to be afflicted, by any ailment; or attaches the title Doctor, Physician, Surgeon, M.D. or any other word or abbreviation to his name, indicating that he is engaged in the treatment of human ailments as a business; and does not possess a valid license issued by the authority of this State to practice the treatment of human ailments in any manner, he shall be sentenced as provided in Section 35.1.
Amended by P.A. 77-2708, § 1, eff. Jan. 1, 1973.

§ 41. Releases from liability as condition of medical treatment is against public policy. Any contract or agreement signed by any person prior to or as a condition of such person receiving medical treatment in any form, which releases from liability any physician, hospital or other health care provider for any malfeasance, misfeasance or nonfeasance in the course of administering any medical treatment or service is void and against the public policy of the State of Illinois.
Added by P.A. 82-280, eff. July 1, 1982.

DEPARTMENT OF REHABILITATION SERVICES

623 East Admas Street
Springfield, IL 62706
Robert W. Granzeier, *Acting Director*

The Department of Rehabilitation Services is a statutory agency which determines medical eligibility for applicants for cash benefits under Social Security Disability Insurance, Supplemental Security Income, provides rehabilitation services and operates residential/educational/rehabilitation facilities for disabled adults and children of or near public school age who cannot be appropriately served by community resources. Clients who have a vocational goal are provided appropriate quality rehabilitation services including evaluation, education, training, guidance, counseling, job placement and other medical and support services. For eligible persons, the Department provides Home Services to severely disabled persons under the age of 60 who do not have a vocational goal but who are at risk of being institutionalized on a long-term basis. All services are provided directly or indirectly by the Department.

ILLINOIS HEALTH FINANCE AUTHORITY

Martin J. Koldyke, Chicago, *Chairman*
Allison S. Davis, Chicago
Joseph B. Fitzer, Chicago
Gregory A. Hasty, Peoria
Phyllis B. Perkins, Winnetka

Medical Legal Information

The purpose of this section is to present to the Illinois medical community a general view of certain medical-legal principles and relationships which many physicians may encounter in the ordinary practice of their profession. Because this article is intended to provide information of a general nature only, specific problems should be discussed with one's individual attorney. While this presentation is not all-inclusive, it will afford an insight into the more common considerations. It should not be construed as presenting legal opinion, rather general considerations. Information is intended to be illustrative only and does not establish nor imply a standard of care.

ISMS LEGAL SERVICES

The Illinois State Medical Society retains, on a continuing basis, a corporate counsel to whom the Society refers legal questions affecting the membership as a whole. ISMS also answers specific inquiries, through the Board of Trustees, made by the component county medical societies when they are of general interest to the medical community. Although the Illinois State Medical Society does not provide personal legal advice to individual members, the Society does believe the following information will help further each physician's awareness of certain basic legal principles and concepts vital to his practice. For personal legal services, members are encouraged to retain an attorney.

THE PHYSICIAN-PATIENT RELATIONSHIP

Contractual Relationship

In most instances the physician-patient relationship is a voluntary, contractual one. Accordingly, physicians are required to accept only those patients they elect to treat. The professional services rendered on behalf of particular patients and the fees compensating the physician for those services are to be agreed between the physician and the patient. Whenever possible, the physician should discuss his fee with the patient in advance of treatment.

While the physician/patient relationship is mutually elective, once the physician has undertaken the treatment of a particular patient, he is under a legal duty, subject to certain exceptions discussed below, to continue his attendance so long as the case requires attention.

A physician may legally terminate his attendance of a particular case in several ways:

1. The contract between the physician and the patient expressly limits the scope of treatment;
2. The patient may discharge the physician;
3. The relationship may end by mutual consent;
4. The physician may legally terminate his services if the patient breaks the contract. In any such instance, personal counsel should be consulted.

When the physician has a reasonable basis to terminate his care of the patient, he must provide the patient with sufficient, reasonable written notice of his intention to withdraw so as to enable the patient to secure another physician. This notice should be in writing and briefly explain to the patient the reason for the intended termination. If the patient returns to the attending physician, and has been unable to procure other medical assistance, the attending physician should *not* refuse continued treatment until a replacement has been secured. Upon request, the physician should make copies of his records of the care he rendered to the patient available to a new physician selected by the patient.

PATIENT RECORDS

Illinois law provides that hospitals in the state shall, upon the written demand of any discharged patient, permit that patient, the patient's physician or authorized attorney to examine and make copies of his medical records. These disclosure provisions do *not* apply in the case of a psychiatrist-patient relationship, except as provided by the Illinois Mental Health Code. With respect to the physician's office records, the statute was amended in 1976 to provide that every physician shall, upon the demand of any patient who has been treated by him, permit the patient's attorney or physician who is currently treating him to examine and copy all medical records in connection with the treatment of the patient. Psychiatric records are excluded, except when ordered by a Court and as provided by the Illinois Mental Health Code. The physician to whom the request is directed must respond within a reasonable time and shall be reimbursed by the patient or his representative for all reasonable costs resulting from examining or duplicating the physician's records.

Physicians should be cognizant of legal requirements for confidentiality of alcohol and drug abuse patient records.

NEGLIGENCE LIABILITY OF PHYSICIANS

Illinois law requires physicians and surgeons to exercise that degree of reasonable skill as is used in ordinary good practice. The failure to exercise such skill can result in liability if the patient is thereby injured.

In recent years, in part through the adoption of new laws, but primarily through court decisions, professional liability has been significantly expanded. A recent ruling of the Illinois Supreme Court, for example, extended liability in a certain

circumstance for birth defects suffered by a child as a consequence of an injury its mother suffered eight years before the child was conceived. The Court reasoned that the defendant hospital and doctor should have known that the harm caused the mother could have resulted in injury to the child born many years later. This case establishes a "chain of accountability" which dramatically increases exposure to liability and underscores the fact that the problems associated with medical malpractice continue to jeopardize the delivery of quality medical care.

The physician is liable for his own negligent acts and the negligent acts of all employees subject to his control or supervision while acting within the scope of their employment. In the case of a partnership, he also may be liable for the negligent acts of his partners.

Today there is simply no existing alternative to carrying adequate liability insurance. However, insurance coverage is not a panacea for expanded liability. Each physician must undertake affirmative efforts to reduce the risks associated with the rendering of health care services.

The American Medical Association published a pamphlet entitled "Professional Liability and the Physician." Twenty guidelines for preventing malpractice actions are set forth in that pamphlet:

1. The physician must care for every patient with scrupulous attention given to the requirements of good medical practice.
2. The physician must know and exercise his legal duty to the patient.
3. The physician must avoid destructive and unethical criticism of the work of other physicians.
4. The physician must keep records which clearly show what was done and when it was done and which demonstrate that the care given met fully the standards of good care as practiced in the community or in similar communities. If any patient discontinues treatment before he should, or fails to follow instructions, the records should show it; a good method is to preserve a carbon copy of the physician's letter advising the patient against the unwise course.
5. A physician must avoid making any statement which constitutes, or might be construed as constituting, an admission of fault on his part. He should instruct employees to make no such statements.
6. The physician must exercise tact as well as professional ability in handling his patients, and should insist on a professional consultation if the patient is not doing well, if the patient is unhappy and complaining, or if the family's attitude indicates dissatisfaction.
7. The physician must refrain from over-optimistic prognoses.
8. The physician must advise his patients of any intended absences from practice and recommend, or make available, a qualified substitute. The patient must not be abandoned.
9. The physician must unfailingly secure a consent, in writing, for medical and surgical procedures and for autopsy.
10. The physician must carefully select and supervise assistants and employees and take great care in delegating duties to them.
11. The physician should limit his practice to those fields which are well within his qualifications.
12. The physician must frequently check the condition of his equipment and make use of every available safety installation.
13. The physician should make every effort to reach an understanding with his patient in the matter of fees, preferably in advance of treatment.
14. The physician must realize that it is dangerous to diagnose or prescribe by telephone.
15. The physician should not sterilize a patient solely for the patient's convenience, except after a complete explanation of the procedure and its risks and possible complications. He must also first obtain a signed consent from the patient and from the patient's spouse, if the patient is married. Eugenic sterilization should be performed only in conformity with the law of the state, if any. Sterilization for therapeutic purposes may be performed lawfully with the consent of the patient and preferably with the consent of the patient's spouse, if the patient is married.
16. Except in an actual emergency situation which makes it impossible to avoid doing so, a male physician should not examine a female patient unless an assistant or nurse, or a member of the patient's family is present.
17. The physician should exhaust all reasonable methods of securing a diagnosis before embarking upon a therapeutic course.
18. The physician should use conservative and less dangerous methods of diagnosis and treatment wherever possible, in preference to highly toxic agents or dangerous surgical procedures.
19. The physician should read the manufacturer's brochure accompanying a toxic agent to be used for diagnostic or therapeutic purposes and, in addition, should ascertain the customary dosage or usage in his area.
20. The physician should be aware of all the known toxic reactions to any drug he uses, together with the proper methods for treating such reactions.

In addition to these general guidelines to good medical practice, the physician should keep current and be in compliance with hospital regulations and standards enforced by governmental agencies, the Joint Commission on Accreditation of Hospitals, and the bylaws of his hospital and its medical staff. The physician has the responsibility to maintain good records of his care of his patients, to recommend consultation when the advice of a specialist is indicated, and to keep his patients informed of the progress of their care. The physician, as a member of an organized hospital medical staff, also has the duty to participate in, and submit to, peer review for purposes of monitoring his professional credentials and performance and for evaluating the quality and appropriateness of the patient care he delivers.

LIMITS ON LIABILITY—SPECIAL SITUATIONS

Under the "Good Samaritan" amendment to the Medical Practice Act, physicians who in good faith provide emergency care without fee to a person, shall not, as a result of acts or omissions, except willful or wanton misconduct, be liable for civil damages.

The Medical Practice Act further provides that any physician, serving on any medical audit or peer review committee, shall not be liable for civil damages as a result of his acts, or omissions, or decisions in connection with his duties on such committee, except those acts, omissions or decisions which involve willful or wanton misconduct.

ILLINOIS CONTROLLED SUBSTANCES ACT

Under the Illinois Controlled Substances Act, physicians who prescribe or dispense various controlled substances are required to register with the Illinois Department of Registration and Education. Physicians who dispense "designated products," must comply with state law requiring the triplicate prescription form, whereby the dispensing physician must submit copies of the triplicate prescription to the Illinois Department of Registration and Education in the same manner as a pharmacist fulfilling that prescription. Categories of drugs under which registration is required are almost identical to those established by the Federal DEA. Registration must be renewed annually.

AUTOPSY

The *Illinois Revised Statutes* specifically detail the conditions under which a physician may perform an autopsy. Essentially, an autopsy may be performed provided:

1. The physician has a written authorization from the decedent to do so; or
2. The physician has a written authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right (a "surviving relative" means the spouse, an adult child, the parent, or an adult brother or sister of the decedent); or
3. The physician has a telegraphic or telephonic authorization from a surviving relative who has the right to determine the method for disposing of the body or a next of kin or other person who has such right. This last provision is conditioned, however, upon the requirement that the telegraphic or telephonic authorization is verified, in writing, by at least two persons who were present at the time and place the authorization was received.

Illinois law specifically provides that where two or more persons have equal right to determine the method for disposing of the body, the authorization of only one such person shall be necessary, unless, before the autopsy is performed, any others having such equal right shall object in writing or, if not physically present in the community where the autopsy is to be performed, by telephonic or telegraphic communication to the physician by whom the autopsy is to be performed.

While authorization may be given to a physician or hospital administrator or his duly authorized representative, only a physician shall perform the autopsy. The authorized personnel of a hospital or other qualified personnel selected by a physician may assist a physician performing an autopsy.

The term "written authorization," provided for above, means any printed, typed or handwritten communication signed by the person granting the authorization.

In order to avoid the possibility of liability, autopsies should only be performed when ordered by the coroner or upon the appropriate written consent of the next of kin as specified above. (The coroner may order an autopsy directly against the wishes of the next of kin). Cooperation should be forthcoming in cases under the coroner's jurisdiction.

CONSENT OF MINORS TO MEDICAL TREATMENT

1. Situations Where Consent Need Not Be Obtained For Treatment of a Minor: Where a hospital or a physician renders emergency treatment or first aid (or a licensed dentist renders emergency dental treatment) to a minor, consent of the minor's parent or legal guardian need not be obtained if, in the sole opinion of the physician, dentist or hospital, the obtaining of consent is not reasonably feasible under the circumstances without adversely affecting the condition of such minor's health.

2. Parental Consent for Treatment of a Minor Child When Parent is Also a Minor: Illinois law provides that any parent, including a parent who is a minor, may consent to the performance upon his or her child of a medical or surgical procedure by a physician licensed to practice medicine and surgery or a dental procedure by a licensed dentist. The consent of such parent is not voidable because of his or her minority, and Illinois law specifically provides that this parent, who is a minor, is deemed to have the same legal capacity to act and shall have the same powers and obligations as has a person of legal age.

The consent to the performance of a medical or surgical procedure, by a physician licensed to practice medicine and surgery, which is executed by a married person who is a minor or by a pregnant woman who is a minor, or a person age 18 or older, is not voidable because of such minority and Illinois law further provides that for such purpose, such married person, who is a minor, or such pregnant woman, who is a minor, or a person age 18 or older, is deemed to have the same legal capacity to act and has the same powers and obligations as has a person who has attained majority (age 18 or older).

3. Birth Control Services for Minors: Birth control services and information may be rendered by doctors licensed in Illinois to practice medicine in all of its branches to any minor who meets any of the following criteria: is married; is a parent; is pregnant; has the consent of parent or legal guardian; as to whom the failure to provide such services would create a serious health hazard; or is referred for such services by a physician, clergyman or a planned parenthood agency.

4. Venereal Disease, Drug Use and Alcoholemia—Consent to Treatment By Minor: Notwithstanding any other provision of law, a minor 12 years of age or older who may have come into contact with any venereal disease or suffers from the use of depressant or stimulant drugs, as defined in the Drug Abuse Control Act, or narcotic drugs, as defined in the Uniform Narcotic Drug Act, or may be determined to be an alcoholic or an intoxicated person, as defined in the Alcoholism and Intoxication Treatment Act, may give consent to the furnishing of medical care or counseling related to the diagnosis or treatment of such disease. Each incident of such venereal disease shall be reported to the State Department of Public Health or the local board of health in accordance with regulations adopted pursuant to statute or ordinance. The consent of the parent, parents, or legal guardian of such minor shall not be necessary to authorize medical care or counseling related to the diagnosis or treatment of such disease or drug or narcotic use or alcohol consumption. The consent of the minor shall be valid and binding as if the minor had achieved his or her majority. Such consent shall not be voidable, nor subject to later disaffirmance, because of minority.

Anyone involved in the furnishing of medical care or coun-

seling related to the diagnosis or treatment of such minor's disease or drug, narcotic or alcohol use shall, upon the minor's consent, make reasonable efforts, to involve the family of such minor in his or her treatment, if the person furnishing such treatment believes that the involvement of the family will not be detrimental to the progress and care of such minor. Reasonable effort shall be extended to assist the minor in accepting the involvement of his or her family in the care and treatment being given.

5. Notification of Parents of Minor Treated for Alcohol Abuse: However in any instance in which a minor above the age of 12 years is being treated for alcohol use the person furnishing such treatment shall notify the parent or guardian of such minor following the second treatment of such alcohol use unless in that person's professional judgment such notification would jeopardize the course of treatment being pursued. In no case, however, shall a period of more than three months elapse without the parent or guardian of said minor being notified of the treatment afforded.

6. Notification of Parents of Minor Treated for Venereal Disease or Chemical Abuse: Any physician who provides diagnosis or treatment or any licensed clinical psychologist or professionally trained social worker with a master's degree or any addiction aid or addiction specialist employed by the Dangerous Drugs Commission or by units of local government or by agencies or organizations operating drug abuse programs funded or licensed by the Federal Government or the State of Illinois or any qualified person employed by or associated with any public or private alcoholism program licensed by the State of Illinois who provides counseling to a minor patient who has come into contact with any venereal disease or suffers from the use of any drug or narcotic or from alcohol consumption referred to in the section immediately preceding may, but shall not be obligated to, inform the parent, parents, or guardian of any such minor as to the treatment given or needed.

UNEMPLOYMENT COMPENSATION

The Illinois Unemployment Compensation law mandates coverage by physicians who employ only one person. If physicians have specific questions regarding the applicability of unemployment compensation to their employees, they should consult the Illinois Department of Labor, Division of Unemployment Compensation, or their attorney.

BLOOD LABELING

The Illinois Blood Labeling Act contains three requirements of particular importance to the medical profession:

1. No person may administer blood by transfusion in Illinois unless the container of such blood is labeled in conformity with regulations developed and specified by the Illinois Department of Public Health;
2. When blood is administered by transfusion in Illinois, the identification number of the unit of blood must be recorded in the patient's medical record and the label on the container of blood may not be removed before or during the administration of that blood by transfusion;
3. As of July 1, 1973, no blood (which has been initially acquired by purchase) may be administered by transfusion in Illinois unless:
 a. The physician in charge of the treatment of the patient to whom the blood is to be administered has directed that such purchased blood be administered to that patient; and
 b. The physician in charge of the treatment of the patient has specified in the patient's medical record his reason for such action.

IMMUNIZATION

In 1973, the Illinois General Assembly eliminated a listing of specific diseases against which there must be immunization and transferred responsibility for determination of these to the Illinois Department of Public Health. Thus, the director will promulgate regulations, which may change from time to time, as to those diseases against which children will be immunized. This affects the School Code and the Communicable Disease Act. A comprehensive treatment of immunization requirements was published in the September, 1980, *IMJ.*

MEDICAL CORPORATIONS

Until 1963, when the Illinois General Assembly passed the Medical Corporation Act, physicians were not able to avail themselves of the legal advantages of doing business as a corporation. A primary reason for forbidding the use of the corporate form for doctors was that the personal assets of the officers, directors and stockholders are generally beyond the reach of creditors, including persons who acquire a legal claim against the corporation after suffering injury resulting from the actions of the agents of the corporation. Because the public wished to insure itself of the best medical care, the law would not permit doctors to insulate themselves from personal malpractice liability by the use of a "corporate shield." However, the corporation can be sued as the employer and the individual doctor-employee can also be sued.

The corporate form does, however, present certain advantages, particularly in the area of taxation. There has never been a compelling reason to deny these benefits to doctors and other professionals.

Under the Illinois law, all the shareholders, officers and directors of a medical corporation must be licensed physicians. In the case of a professional services corporation also authorized under current Illinois law, the secretary of the cor-

poration need not be a physician.

The corporation must register with the Illinois Department of Registration and Education under whose auspices it is permitted to operate, in addition to the requirements of filing with the office of the Secretary of State. This law explicitly denies physicians working within a corporation the right to insulate their personal assets from malpractice liability.

MDs EXCLUDED FROM 'CERTIFICATE OF NEED' CONTROLS

Plans to build, expand, move or sell a hospital, nursing home or surgicenter require approval of the State Health Facilities Planning Board.

A provision in the original legislation which would have brought physicians' offices and clinics under "certificate of need" regulation was withdrawn because of vigorous ISMS opposition. At the federal level, renewed efforts are underway to bring all outpatient facilities, including the doctor's office, under the provisions of the law.

This law covers construction or modification plans involving an expenditure of more than $150,000, or a substantial change in services or bed capacity.

Under Public Law 93-641, local Health Services Agencies are to hold public hearings on all applications for construction or expansion of facilities before submitting a recommendation to the state Health Planning Board for final action.

The state agency is required to study: (1) area size; (2) population and growth potential; (3) number of existing and planned facilities offering similar services; (4) utilization of existing facilities; (5) availability of alternative facilities and services; and, (6) availability of necessary personnel.

Undoubtedly, the role of health planning agencies will expand and the physician will feel the effects and influence of regulations promulgated by these organizations. While the private practice of medicine is as yet relatively "free" of the jurisdiction of these agencies, the decisions of the Board are already reaching out to limit the purchase of new equipment and the development of new services by hospitals and other institutions in which the doctor performs many of his professional services. It is reasonable to expect that with the current government emphases on cost containment in health care, the physician's practice can and will be affected. Therefore, it is in each physician's best interest to monitor these developments closely in the months and years ahead.

CURRENT DEVELOPMENTS IN HEALTH LAW

The current health scene is shaped, at least in part, by the adoption of a multiplicity of new laws and regulations, by court decisions and by the methods employed by the many agencies functioning at all levels of government. For example, the Federal Trade Commission continues its aggressive investigations of the health field, even though a Supreme Court decision diluted their efforts to eliminate the use of a Relative Value Scale in setting fees for anesthesiologists.

Unfortunately, litigation based in medical malpractice is increasing once again, stimulated by recent court decisions which expand liability for doctors and hospitals. One set of decisions by the Illinois Supreme Court gave new impetus to the practice of apportioning "fault" among joint-tortfeasors. It heightened the prospect of hospitals and doctors suing each other in third party lawsuits in order to distribute the responsibility for settlements and judgments arising out of negligence lawsuits based on the degree of liability attributed to each named co-defendant. The added stress and costs will not be absorbed easily by the health field. Another recent Illinois Supreme Court decision ruled that radiation (used in therapy) is a product, not a professional service, and, as such, shall be governed by the legal doctrine of *strict* liability. This decision places a higher standard of care on doctors and hospitals in the circumstances surrounding the administration of radiation therapy. There will exist a kind of "presumption" of negligence in any case resulting in an injury to a patient who has received radiation.

In response to these and earlier developments in the field of health law, the Illinois State Medical Society, through its Board of Trustees, addresses specific issues and attempts to take action to obviate or minimize negative impact on physicians or the profession.

ILLINOIS LAW

In a complex, technology-oriented society, with an ever-increasing degree of sophistication among consumers, and a burgeoning bureaucracy, laws and regulations have been put into place to protect the public good. While restrictive laws are regarded as impositions by some, they are a fact of life. Some laws, of course, are viewed differently by different people. And some laws are considered by some to be unjust, discriminatory, or inequitable. Generally, however, most people recognize the need to have an orderly system under which the affairs of society are conducted.

With respect to the practice of medicine, many sections of the statutes refer to items controlling or describing activities of a physician. Others limit the public. Further references govern various health care situations in society. All physicians are impacted upon by the statutes, and by the Rules and Regulations, if any, implementing them. It is important that there be knowledge of these laws. It is just as important that physicians have a personal attorney to assist in assuring compliance with the statutes.

By reference to the volumes codifying Illinois law, one can generally identify if any particular statute applies to oneself in a given situation. To help ISMS members find these, the three volumes of *Illinois Revised Statutes* (1979) have been researched. While it would be impossible to reprint all pertinent parts of the laws, an index has been developed. This sets forth the chapter and statute section, and the title of the Act or section. Using this and referencing the statutes (available in all libraries, attorneys' offices, as well as other locations), one can read what the law says on the subject contained therein.

Rather than attempting to lump the statutes into subject groupings, a straight run through has been accomplished. Groupings would result in duplication and possible misinterpretations. While the listing is as complete as possible, it is possible that some items could have been overlooked. Notification of omission, to *IMJ*, would be appreciated. No interpretation is intended or implied; every physician should consult an attorney to determine application to individual situations.

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Joint Commission on Accreditation of Hospitals Medical Staff Standards

Principle

There shall be a single organized medical staff that has the overall responsibility for the quality of all medical care provided to patients, and for the ethical conduct and professional practices of its members, as well as for accounting therefore to the governing body.

Standard I: The medical staff shall assure that each member is qualified for membership, and shall strive to maintain the optimal level of professional performance of its members through the appointment/reappointment procedure, the specific delineation of clinical privileges, and the periodic in-depth reappraisal of each staff member. *(Interpretative information accompanying this standard details provisions for qualifications, method of selection, privilege delineation and staff reappointment/reappraisal.)*

Standard II: The medical staff shall be organized to accomplish its required functions. *(Interpretative information accompanying this standard details provisions for medical staff categorization, e.g., active, associate, courtesy, consulting, and honorary staff; provisional and temporary status, medical staff officers, executive committee and departments.)*

Standard III: The medical staff shall develop and adopt bylaws, rules and regulations to establish a framework of self-government and a means of accountability to the governing body.

Standard IV: The medical staff shall provide mechanisms for the regular review, evaluation, and monitoring of medical staff practice and functions. Such mechanisms shall be designed to maintain high professional standards of care. *(Interpretative information accompanying this standard details provisions for tissue review, pharmacy and therapeutics and medical record functions, blood utilization and antibiotic usage review and other staff functions.)*

Standard V: The medical staff shall participate in a program of continuing education.

The Joint Commission on Accreditation of Hospitals recently revised the Accreditation Manual for Hospitals. A copy of the revised manual has been sent to each accredited Illinois hospital. The medical staff standards are given extensive interpretation, which is not included herein, but should be obtained from the revised manual for a full understanding. The new manual also includes extensive revisions in several other sections, which impact on medical staff activities, and should be examined.

In significant part, this section is reprinted by permission from the "JCAH Accreditation Manual for Hospitals," 1982 edition, pages 93-109.

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Abstracts of Board Actions

(Continued from page 280)

ICCME

Following an in depth study of the structural relationship of ISMS and the Illinois Council on Continuing Medical Education (ICCME), the Board reaffirmed the present relationship between ISMS and ICCME, but approved several revisions in that relationship:

1. ICCME will remain a separate corporate entity and continue the current method of appointing members to its Board of Directors.
2. The staff functions of ICCME will be transferred to a Division of Education within the staff structure of ISMS. The director of that division would be an appropriately qualified professional educator. The ICCME Board would act as a consulting committee in the selection of a suitable candidate, but personnel decisions and other administrative matters would remain within the purview of the ISMS Executive Administrator. The ICCME Board also would continue to direct division functions relating to ICCME.
3. ICCME activity under the new structure would be funded from AMA-ERF, membership dues from ISMS and such other funds as can be received from grants.

The Board deferred action on recommendations from the Committee on CME Accreditation regarding the second draft of the *Essentials for the Accreditation of Sponsors of Continuing Medical Education* adopted by the Accreditation Council for Continuing Medical Education. Also deferred was action on a recommendation that the Committee be allowed to grant "probational" accreditation to CME sponsors which had been granted "provisional" status earlier rather than be forced to either grant full accreditation or non-accreditation.

POLICY REVISIONS

Upon recommendation of its Policy Committee, the Board agreed to submit resolutions to the House of Delegates to revise ISMS policies on "Physicians," and "ISMS Candidates for AMA Positions." The Board also voted to retain policies on "Freedom of Choice," "Professional Liability," "Prolonging Human Life," "Medical Testimony," and "Electromyoneurographic Procedures and Examinations." Deletion of the Society's policy on "Birth Certificates" will be recommended to the House.

Based upon actions at the last House meeting, the Board adopted the following policies for publication in the policy manual:

Health Systems Agencies (Res. 36-A81)

The Illinois State Medical Society supports legislative activity by the American Medical Association repealing the Federal Health Planning Act, Public Law 93-641 and Public Law 96-79 as amended. As an interim policy, ISMS will seek legislative amendment in Congress or an administrative exemption removing those portions of the Health Planning Act which impose penalties on states not in compliance with Federal SHPDA designated criteria.

Hospices (Res. 12-A81)

A hospice is a centrally administered program of palliative and supportive services providing medical, social, psychological and spiritual care for terminally ill persons and their families. Services are provided by a medically-supervised, interdisciplinary team of professionals and volunteers. Care is offered 24 hours a day, seven days a week, through either inpatient settings, home care or a combination of both. Bereavement counseling is provided for the survivors.

IDPA Drug Manual (Res. 44-A81)

ISMS approves the concept that pharmaceutical products for inclusion in the IDPA Drug Manual be based on therapeutic effectiveness rather than cost. While ISMS members will continue to be cost conscious in all aspects of medical care, this care must be based upon therapeutic considerations and bioequivalence.

Anaphylactic Reactions to Insect Stings (Res. 2-A81)

ISMS favors development of mechanisms to allow the availability of epinephrine, through appropriately trained persons, upon the prescription of a physician.

Cardiopulmonary Resuscitation (Resolution 27-A81)

ISMS encourages basic cardiac life support training in Illinois high schools.

Reimbursement for Treating Medicaid Patients (Res. 40-41-A81)

The Illinois State Medical Society approves in principle the concept of amending appropriate state and federal laws to provide physicians with the option of taking state and federal income tax credits or deductions in lieu of direct reimbursement for the treatment of public aid recipients.

55 M.P.H. Speed Limit (Res. 34-A81)

The Illinois State Medical Society opposes an increase in the 55 mile-per-hour speed limit.

The Board added the following language to the Society's policy on "Medical Education—Schools": "ISMS supports the concept that Illinois medical students, whose medical education is supported by Illinois tax money, be encouraged to remain in Illinois to practice." Editorial changes in the preamble of the policy manual and the policy on "Mental Health" also were adopted. A proposed revision in policy on "Expert Witnesses" was referred to the Medical Legal Council and a policy statement on "Utilization Review, Commercial" was referred to legal counsel for further study.

FINANCIAL MATTERS

Upon the recommendation of its Finance Committee, the Board accepted a proposal by Ernst and Whinney to conduct a study which would: (1) Analyze the Society's financial situation in context of its current five-year dues plan; (2) Guide ISMS in developing its reserve funds; and (3) Determine the need for a dues increase. The accounting firm agreed to conduct the study at no charge to the Society. Ernst and Whinney currently serves as auditors for ISMIE and ISMIS.

In other financial matters, the Board:

1. Agreed to transfer $217,278 from the contingency fund to the operating fund to offset expenses incurred in the Society's defense of the Wilk case.
2. Approved 41 changes in dues status, including 23 exemptions for cause, eight transfers to emeritus and 10 transfers to retired.
3. Eliminated the mandatory 5% employee contribution to the pension plan.
4. Authorized retention of a new ISMS staff member to oversee an expanded marketing program to increase the number of ISMS, ISMIE, and IMPAC members. Costs for the new employee will be shared by ISMS and ISMIS, although retention of a suitable individual and administrative authority will remain the responsibility of the ISMS Executive Administrator.

LEGISLATION

The Board approved a stand of no opposition to legislation mandating the use of motorcycle helmets. Draft legislation on rural and urban health initiatives, insurance reimbursement for emergency medical care, and revisions in the Nurse Practice Act was referred to appropriate ISMS Councils for further study. The Board also agreed to submit to the House of Delegates a resolution directing ISMS to amend current policy to allow ISMS to seek legislation which would provide for the following legal definition of death:

> A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

HEALTH PLANNING

The Board voted to submit two resolutions to the House of Delegates concerning health planning. The first would direct the Board to investigate potential for state planning legislation in the event the federal planning law is not renewed and make recommendations about what would constitute acceptable and unacceptable elements of a state planning program. The second resolution would urge legislators and planning officials to separate planning functions from health regulatory functions in accordance with the definition of health planning in the AMA statement on Voluntary Health Planning.

IDPA DRUG MANUAL

The Board approved the following drugs for inclusion in the IDPA Drug Manual: Zomax, Ascendin, RID, Liban Spray, Albuterol Inhalor, Nubain, Ludiomil, and Capoten (prior approval only). IDPA recently informed ISMS that the Department, rather than the Society's Committee on Drugs and Therapeutics, will grant special approval for use of drugs not appearing in the IDPA Drug Manual.

HMOs

The Board will recommend to the House of Delegates a resolution supporting development of public education materials delineating the positive aspects of existing modes of medical treatment. The Board action is coupled with a recommendation to not adopt Resolution 16-A81 which would have directed ISMS to actively oppose establishment of HMOs and IPAs. An audio-visual presentation explaining the differences between HMOs and fee-for-service practice was presented to the Board and approved for showing at the Leadership Conference being held in conjunction with the HOD Interim Session.

PHYSICIAN LIABILITY FOR STATE SERVICE

At the Board's direction, representatives of ISMS will meet with the Governor's aides to urge the Administration to seek legislation to broaden the State Employees Indemnification Act to include individuals appointed to state boards, commissions and committees. ISMS will express its reluctance to nominate physicians for state bodies unless adequate protection from liability can be assured.

The Board action stems from the Illinois attorney general's recent opinion that the state cannot indemnify or defend a physician who is being sued as the result of his action as an IDPH consultant in an investigation of a hospital's activities. Since ISMS had recommended the physician for appointment as the consultant, the Board agreed to provide up to $5,000 in legal fee assistance to the physician.

STAFF REORGANIZATION

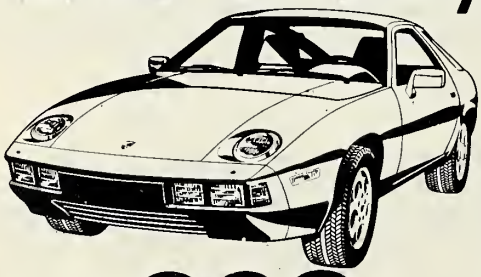
The Board of Trustees was informed of the revised structure of the ISMS staff which is being changed effective January 1. The new organization will offer several important advantages, including a more pyramidical structure, increased delegation of responsibility and increased upward mobility for employees. The new structure also is being designed to allow a distinction between "administration" of ISMS and "management" of the Society's programs and activities. A revised organizational chart will appear in an upcoming issue of *IMJ*.

OTHER ACTIONS

In other actions during its meeting, the Board of Trustees:

1. Appointed a study committee to examine options available when the lease on the Society's office space expires in November, 1984.
2. Approved the nominations of: Dr. John Masterson, former dean of the Loyola Medical School, for the AMA's Distinguished Service Award; and W. Clement Stone for the AMA Citation of a Layman for Distinguished Service.
3. Encouraged county medical societies to process pending membership applications on a timely basis.

4. Authorized ISMS to join the Illinois Hospital Association in filing an amicus curiae (friend-of-the-court) brief in a case before the Supreme Court addressing the issue of patient confidentiality. The case involves a Madison County states attorney seeking to examine local IDPH patient records on venereal disease treatments in an effort to discover potential witnesses against an IDPH employee accused of molesting female patients. Total ISMS expenditures in the action are expected to be $200.
5. Postponed a planned symposium on allied health as part of the ISMS Leadership Conference, Nov. 5-7, due to a conflict with the annual meeting of the Illinois Nurses Association. The Board also agreed to co-sponsor with INA a program on communications between physicians and nurses, subject to INA approval.
6. Authorized development of a pilot five-minute public service radio program to be distributed to Illinois stations. The program would be moderated by the ISMS president and would focus on social, economic and medical issues affecting patients.
7. Approved advertising rate hikes of 10% for black and white and 5% for color ads for the *Illinois Medical Journal.* Rates for classified ads and subscriptions were held constant.
8. Endorsed an IDPH pilot program to test the effectiveness of a "tickler card" system to insure that children receive required immunizations.
9. Encouraged workmen's compensation insurance carriers to utilize county peer review systems to review physician services rather than establishing a new layer of arbitration panels. The Illinois Department of Personnel will be encouraged to also use appropriate county medical societies for specialist review when state employees are involved. ISMS will assist insurers in efforts to educate physicians about the rehabilitation of insured workers and methods of facilitating the employee's return to the workplace.

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The following ISMS-sponsored travel programs have been scheduled for 1982: Feb. 13-22-Ski Holiday in Innsbruck; March 6-13-Mexician Rivera on the Love Boat; May 15-25-Nile River Cruise; Aug. 24-Sept. 2-Canadian Rockies Adventure.

Reservations cannot be accepted unless they are submitted on the official form printed in promotional brochures which are mailed to all ISMS and Auxiliary members. Individuals outside a member's immediate family will be placed on standby status until all ISMS members have had reasonable time to make reservations. Promotional expenses connected with these programs are paid by the tour operator. Contact ISMS headquarters for additional information.

IMPAC

Illinois State Medical Society
Political Action Committee
55 East Monroe Street
Chicago, Illinois 60603
312/782-1963

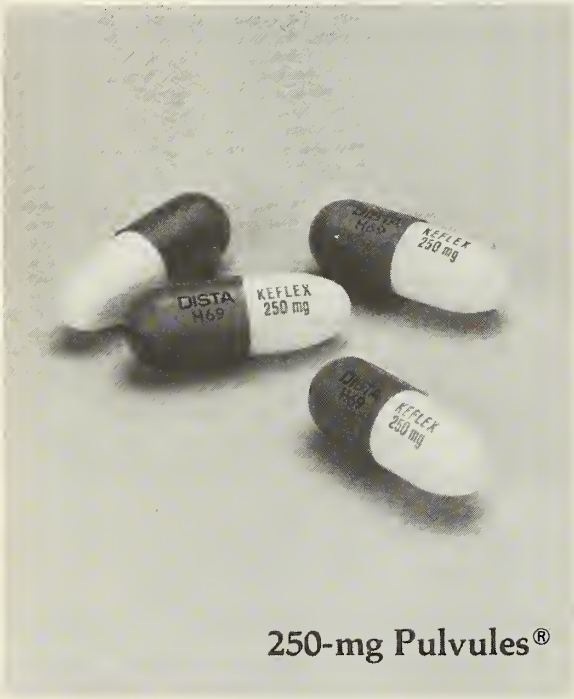
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Medical Student Section in Action

Enrichment Years

The concept of an enrichment year is not new. However, in Illinois, it is still unusual. A growing number of students feel dissatisfied with their experiences in the pre-clinical sciences. Many students feel that these years are treated only as preparation for the National Board Exam, Part I, with little emphasis on integrating information. Post-sophomore programs offer medical students an opportunity to spend a year with a clinical faculty (pathology, medicine, *etc.*). This gives them an early foothold in literature and allows the information from preclinical years to form a cohesive framework for differential diagnosis. The benefits of such programs are not limited to the students.

The school also benefits. Typically, a well-run post-sophomore program infuses its students with an enthusiasm for medicine that spreads very quickly. Coupled with the evidence that these students are significantly more prepared for their clinical years, the school becomes more competitive for placement in prestigious residencies. In two ways, then, the school's reputation is improved—initially, by better residency placement and secondly, by an enrichment program that entices better students to that school.

The staff of the school benefits on several accounts as well. The interaction of students and instructors in the post-sophomore year allows continuity of teaching with a one-on-one approach. Weaknesses can be strengthened and strengths can be challenged to become stronger. Often, attending physicians working in these programs report that they enjoy the challenge of student discussions stemming from current literature. The clinical staff benefits as well. They find it refreshing to speak with students who have read and are able to use the information of researchers on a wide variety of topics. It is not unusual for post-sophomore students to be treated as residents in their interactions on the floors.

It is clear though, that the greatest benefit of an enrichment program is the individual student. The awareness of how much there is to know and how little one knows allows a student to judge his or her capabilities. The structure of the year allows the student to pursue ideas of interest, understand previously cloudy concepts and hear experts on a wide variety of topics. Most rewarding however, is the opportunity to learn to keep current with the literature. It is a frightening experience to see a doctor who hasn't turned the pages of a journal in years. Understanding current problems in the literature as well as studying classic papers in any area provides a necessary professional framework. And it is easier to keep up, once the journals and authors have become familiar.

Clearly, these programs can have a positive long-range effect on our profession. Taking a year during medical training allows the physician in later years to be self-motivated in continuing education. It is worth the time of every medical student who is interested in this to seek out such a program or to urge his or her own clinical departments to offer them. As students have already discovered, even on bad days, one can't help but learn—the educational potential is so great.

Linda Tetzlaff, Secretary/Editor
ISMS/MSS

Linda Tetzlaff is currently doing a Post-Sophomore Program with the Department of Pathology, Rush-Presbyterian-St. Luke's Hospital.

This article represents the opinion of its author only, and is not intended to reflect the opinions or policies of the Illinois State Medical Society or the ISMS Medical Student Section.

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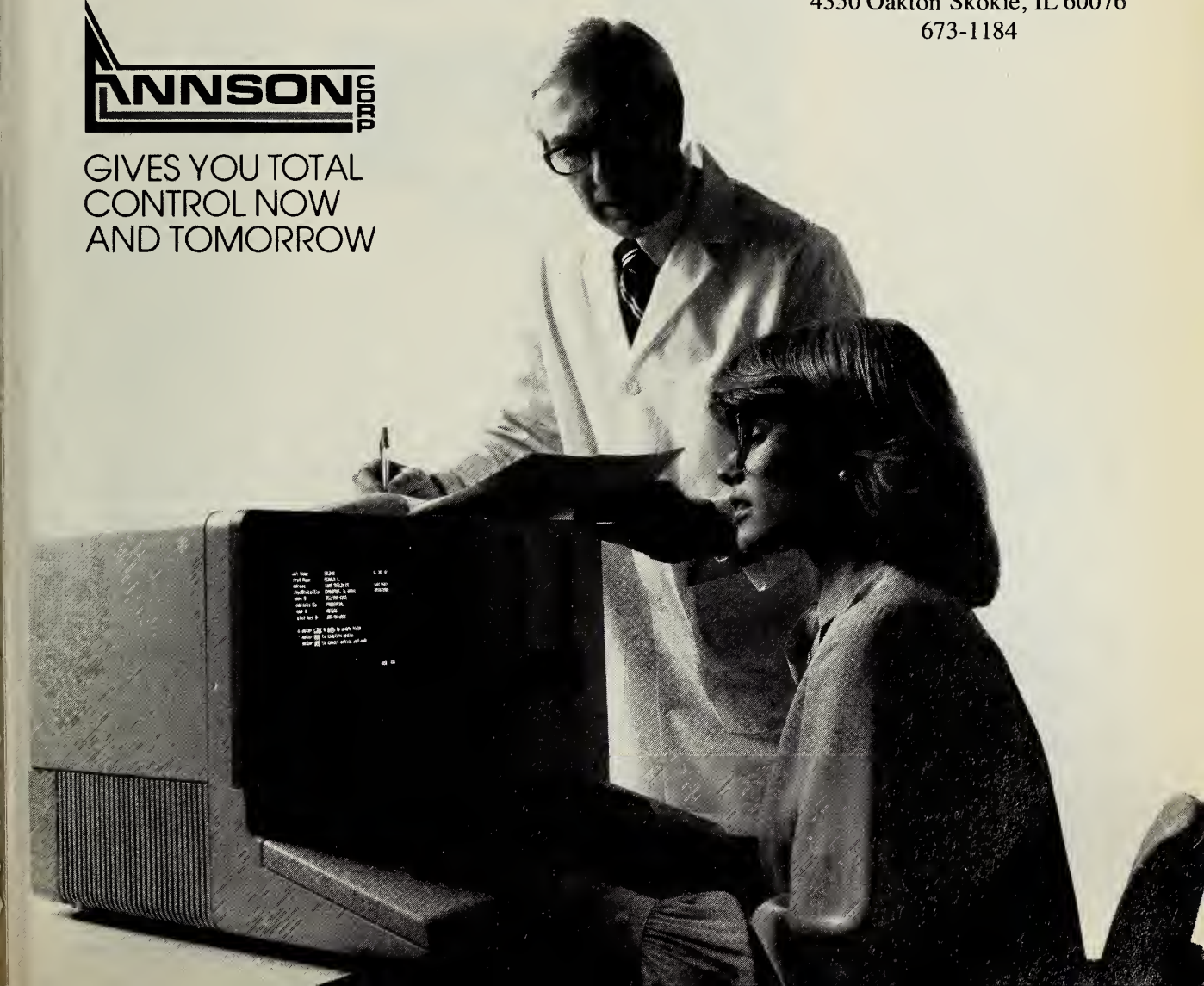
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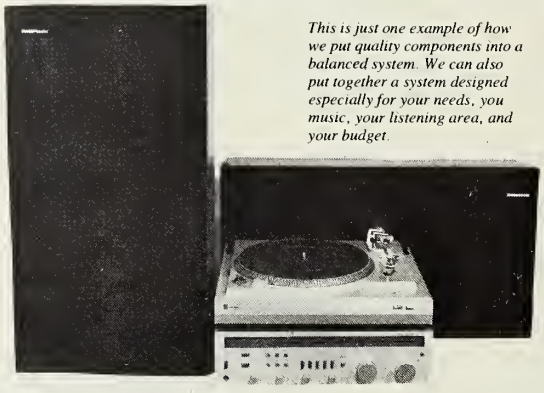
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Illinois Society, American Association of Medical Assistants

National Convention

Illinois Society representatives attended the 25th annual national convention of AAMA at Milwaukee, Wisconsin in September. That gathering was intended to evaluate the progress of AAMA over the last 25 years and reaffirm that the association's founding goals were still attainable.

Robert R. Hartman, M.D., of Jacksonville, Illinois, was elected to the national physicians' advisory board. John L. Wright, M.D. and Dr. Hartman were honored at a reception sponsored by the Illinois Society. Dr. Wright has completed his term of office as physician advisor for the national organization.

As an Illinois State Medical Society liaison, Dr. Hartman anticipates a renewed commitment on the part of AAMA members and physician-advisors. Illinois Society seeks recognition from Illinois physicians and acknowledgment of the value of AAMA membership for their health care personnel.

National officers in attendance from Illinois included Luella Mitchell, CMA, vice-speaker of the AAMA House of Delegates. Ina L. Yenerich, RT,CMA-AC, executive director, AAMA, reported on the current status of AAMA activities. Cissy Egly, CMA, coordinated the 25th Anniversary convention events. Vivian Kraft, CMA-AC, served on the national convention credential committee, and Jean Fouts, LPN, chaired the committee for the election of Dr. Hartman and the reception honoring Dr. Wright and Dr. Hartman.

Further information regarding AAMA may be obtained by contacting Mary Lu Ostrowski, CMA, president, Illinois Society, 1704 East Jackson Street, Bloomington, Illinois, 61701, or Mari Lakadat, chairman, Public Relations Committee, c/o William Sawyer, M.D., 107 East Chestnut Street, Bloomington, Illinois 61701. ◀

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OBITUARIES

***Bugsch, Ludvik A.,** Chicago, died September 22, 1981, at the age of 68. Dr. Bugsch was a 1940 graduate of medical school in Czechoslovakia.

****Burt, Elliott,** Peoria, died September 7, 1981 at the age of 78. Dr. Burt was a 1929 graduate of the Northwestern University Medical School.

****Cassidy, George P.,** Waukegan, died July 10, 1981, at the age of 93. Dr. Cassidy was a 1926 graduate of the University of Health Sciences, Chicago Medical School.

****Cassidy, Raymond M.,** Oak Park, died July 5, 1981 at the age of 80. Dr. Cassidy was a 1929 graduate of Rush Medical College.

***Ciulini, Fausto,** Chicago, died August 29, 1981 at the age of 71. Dr. Ciulini was a 1938 graduate of the Chicago Medical School.

***Chrisos, Sam S.,** Chicago, died September 7, 1981, at the age of 67. Dr. Chrisos was a 1940 graduate of Rush Medical College.

****Coombs, Arthur J.,** Chicago, died July 1, 1981, at the age of 85. Dr. Coombs was a 1926 graduate of Rush Medical College.

Felix, E. Robert, died September 9, 1981, at the age of 53.

****Fischer, Jacob Warren,** Oak Park, died September 5, 1981, at the age of 82. Dr. Fischer was a 1925 graduate of the University of Illinois College of Medicine.

***France, George W.,** Bloomington, died August 19, 1981, at the age of 65. Dr. France was a 1943 graduate of the Northwestern University Medical School.

***Goldfarb, Irwin,** died September, 1981, at the age of 54. Dr. Goldfarb was a 1952 graduate of the University of Illinois College of Medicine.

***Houda, Leonard J.,** River Forest, died August 29, 1981, at the age of 74. Dr. Houda was a 1933 graduate of the Chicago Medical School.

***Kohut, Heinz,** Chicago, died October 8, 1981, at the age of 68. Dr. Kohut was a 1938 graduate of a medical school in Wien, Germany.

Kolski, Bob Peter, Niles, died July 19, 1981, at the age of 51.

***Mousakeotis, Theodore C.,** Chicago, died October 12, 1981, at the age of 74. Dr. Mousakeotis was a 1935 graduate of the University of Illinois College of Medicine.

***Neece, I. Keeth,** Decatur, died August 28, 1981, at the age of 63. Dr. Neece was a 1943 graduate of the St. Louis University School of Medicine.

***Palka, Leonard J.,** Cicero, died September 23, 1981, at the age of 62. Dr. Palka was a 1943 graduate of the University of Illinois College of Medicine.

***Purcell, Matthew J.,** Chicago, died September 6, 1981 at the age of 67. Dr. Purcell was a 1939 graduate of the Loyola University Stritch School of Medicine.

***Russo, Michael J.,** Champaign, died October 7, 1981, at the age of 54. Dr. Russo was a 1954 graduate of the Georgetown University School of Medicine.

***Serota, Herman M.,** Chicago, died September 5, 1981, at the age of 67. Dr. Serota was a 1938 graduate of the Loyola University Stritch School of Medicine.

***Valenti, Dan A.,** Oak Park, died September 28, 1981, at the age of 68. Dr. Valenti was a 1943 graduate of the University of Illinois College of Medicine.

Weber, Frank C., Vincennes, Indiana, died August 24, 1981, at the age of 77.

***Wieneke, Carter H.,** Chicago, died September 4, 1981, at the age of 65. Dr. Wieneke was a 1943 graduate of the Northwestern University Medical School.

***Wrork, Donald H.,** Rockford, died September 13, 1981, at the age of 71. Dr. Wrork was a 1934 graduate of the Northwestern University Medical School.

***Zmigrodski, Theodore F.,** Chicago, died September 20, 1981, at the age of 67. Dr. Zmigrodski was a 1941 graduate of the Loyola University Stritch School of Medicine.

* *Indicates ISMS Member*

***Indicates Member of the ISMS Fifty Year Club*

Pulse of the ISMS Auxiliary

From the Desk of the President

AMAA Confluence

By Bonnie Keegan, ISMSA President

As I prepare this article I am attending the AMA Auxiliary 1981 Leadership Confluence at the Drake Hotel, Chicago. The Confluence is designed to assist in preparing county presidents-elect nationwide for future leadership. These are our dues dollars being returned to the grass-roots, the county.

The seminars presented were: Parliamentary Procedure; Speeches: The Preparation and Delivery; Building a Winning Team (Motivation); Coalitions: Building, Managing and Reaching Out; Public Relations: How to Influence; Committees: How To Make Them Work; All You Need To Know About Being a Leader; "Help! I'm the Parent of a Teenager;" Life Stress Management Without Substances; Substance Abuse; Home and Street Safety; The Aging Population and The Family of the Impaired Physician.

To give everyone in the state an opportunity to study the subject matter at their discretion, all the seminars were taped and are available through the Auxiliary office: 104 E. Broadway, Room 5, Monmouth IL 61462. A summary of each seminar will appear in the quarterly PULSE issue.

Marie Kisiel, Ph.D., professor of humanities, Roosevelt University, Chicago, discussed "How to Become a Leader." She quoted Henry Ford: "The question, 'Who ought to be boss?' is like asking 'Who ought to be the tenor in the quartet?' Obviously, the man who can sing tenor." She also stated, "There is no one right way to become a leader. It is best, therefore, to understand your own leadership traits and qualities, and determine how you can develop those characteristics that will make you an even more successful leader." Dr. Kisiel proceeded to describe leadership styles and skills. We all gained a greater insight into the leadership roles in our Auxiliary.

SPECIAL NOTE: ISMS Auxiliary also provides leadership seminars for ALL county leaders or potential leaders (at no cost to the auxilian). County presidents, please encourage your county officers to attend future seminars. ◀

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Illinois Housestaff News

Thoughts on Health Care Economics

By David J. Palmer, M.D./ Chicago

Diminishing government bureaucracy, budget reconciliation, and tax cuts have been hallmarks of the present administration. Approximately $2 billion of the multi-billion dollar budget bill slashing for 1982 is slated for health spending. This is primarily in Medicaid and Public Health Service programs. According to *AM News,* hospitals and their staffing, residencies, and finally the general public will feel repercussions.

Although the Reagan administration proposed to establish a 5% cap on growth of the Medicaid program, Congress instead adopted an ageement (*Internal Medicine News*, 9/81) that provides for a 3% cut in anticipated Medicaid matching funds to each state in 1982, a 4% cut in 1983, and a 4.5% cut in 1984, resulting in a $1 billion cut per year. A state could lower its amount of reduction if it had a qualified hospital cost review program at the bill's enactment, if state unemployment rate exceeds 150% of the national average, if it holds the rate of medical cost increase below a designated target, or if it demonstrates recoveries from fraud and abuse control activities equal to 1% of federal Medicaid payments.

HHS requirements for PSRO performance assessment would assist HHS in terminating up to 30% of PSRO's functioning in May, 1981 (including those terminated as of September, 1981) by September, 1982, (*AM News*, 8/81) forcing the states to contract with PSRO's to conduct medical reviews. According to *IMJ*, the Act provides that the Secretary of HHS will be permitted to waive freedom of choice for Medicaid beneficiaries of health care services under specified circumstances. States like Illinois may implement case management or specialty physician arrangements, and can restrict Medicare/ Medicaid beneficiaries to a single primary care physician if specific requirements are met.

Illinois is anticipating the above-noted criteria, and we, as residents, should be aware of them. Currently, legislation and law-suits are pending on Medicaid reimbursement policies which would affect hospital welfare charges for inpatient, clinical and emergency room/outpatient services (*AM News*). Of particular concern is whether provisions of these services will result in obligatory scaling—either by condensing the size and salaries of housestaffs, or by altering the quality of available health care to indigents—which would also adversely affect the educational experience of residents, and possibly the attractiveness of Illinois teaching programs. Many major teaching centers in Chicago have had a 10-14% budget cut, according to the *Chicago Tribune,* from dwindled Medicaid reimbursements. That story alleged that some hospitals no longer serve public assistance patients unless lives are threatened, or are compelled to transfer patients to an over-burdened Cook County Hospital which could lose approximately $16 million under expected cuts. And Cook County Hospital cannot remain solvent forever.

The budget bill includes legislation to consolidate 20 categorical programs into four block grants—maternal and child health, preventive health and health services, primary care, and alcohol, drug abuse and mental health—leaving ten separate federally-operated categorical programs and cutting spending by 25% over three years. The law requires each state to tell how it intends to spend its block grant funds with an ear for citizen input. Attempts to appropriate funds to specific areas necessary and important to resident patient care and training are mandatory at this level. Organized support from those hospitals with residency training programs, especially in indigent areas, must echo a resounding, unified voice so they may receive just remuneration for their debt-ridden services.

Medical school capitation funds were terminated creating a $40 million loss to receivers. The rising cost of tuition, as high as $26,000 for out-of-state residents at one state school, (*The New Physician,* 9/81) effectively could screen the more financially able medical school applicant. Once accepted, the prospective student may find a large facility with little ancillary assistance. Of note, approximately 7% of the nation's work force is employed in the health field (*U.S. News & World Report*, 8/81). Faced with budget restraints, hospitals in the Chicago area, alone, may lay off 1300 employees creating greater unemployment and ancillary deficits (*AM News*, 8/81). As the hy-

(Continued on page 393)

Screening for Asymptomatic Bacteruria In a Disadvantaged School Population

By Eugene F. Diamond, M.D., Diane Leyland, R.N., M.S.
and Margaret Novy, R.N., M.S./Maywood

The entire seventh grade population of a suburban Chicago school district, consisting of 147 males and 167 females, was screened by a dipstrip to detect nitrite, glucose, and protein. Where one or more of the dipstick tests was positive, urine cultures were performed on clean voided specimens. A child whose urine culture showed a colony count of greater than 100,000 colonies/ml was diagnosed as having asymptomatic bacteruria. 5.4% of the female students were found to have asymptomatic bacteruria. None of the male students were so diagnosed.

While bacteruria in a school girl seldom leads to end stage renal failure or hypertension, it is not an entirely benign condition. Asymptomatic bacteruria may be the first clue to the existence of underlying anatomic abnormalities. In others, it may signal the onset of recurrent symptomatic infections and a susceptibility to urinary tract infections during pregnancy.[1]

Some investigators in the United Kingdom and Sweden[2-4] have questioned the need for the treatment of children with asymptomatic bacteruria and have cast doubt on the value of screening large school populations.

DIANE LEYLAND, R.N., M.S., is a family nurse practitianer affiliated with the Pasen-Rabbins School Health Carparatian in Pasen, Illinais. A graduate of the UI Medical Center master af science in nursing pragram, Ms. Leyland farmerly served as a teaching assistant in the Rush-Presbyterian-St. Luke's Medical Center pragram far Cammunity Health Nursing. She has also worked as a public health nurse.

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EUGENE DIAMOND, M.D., is a baard certified pediatrician in private practice. A prafessar af pediatrics at the Layala University Stritch Schaal of Medicine and visiting prafessar at Rush Medical Callege, Dr. Diamand is medical directar af the Pasen-Rabbins Schaal Health Carparatian.

Method

The population which was screened in this study was an entire seventh grade pupil population. Permission was solicited from patients and specimens were collected during gymnasium class periods using the methods recommended by Kunin.[2] A total of 314 students participated, of whom 147 were males and 167 were females. All students ranged in age from 12-14 years. All specimens were tested, initially, with a dipstrip used to detect nitrite, glucose, and protein. All students who had a positive finding in any or all of the areas of dipstick detection had cultures done on two clean voided specimens.

Results

Among the specimens provided by the male students, there were no positive tests for either nitrite or glucose. Three of the specimens were positive for protein but none of the students proved to have significant bacteruria on either of two clean voided specimens examined subsequently by culture. Growth on culture ranged from 10,000-25,000 colonies/ml among specimens obtained. One student who was found to have a persistent heavy proteinuria was diagnosed on subsequent evaluation as having orthostatic albuminuria. The other two male students had only transient proteinuria for which no cause was found.

Among the specimens voided by female students, one was positive for glucose (in a known juvenile-onset diabetic) and fifteen were positive for protein on dipstick. Two were positive for nitrite only and one was positive for nitrite and protein. Eight of the female students were found to have a significant bacteruria as demonstrated by colony counts over 100,000 colonies/ml on two subsequent clean voided cultured specimens. Six of the patients who had a growth of more than 100,000 colonies/ml had shown a positive reaction only to protein. On the dipstick, one had been positive for nitrite and protein and one had been positive for nitrite only. All eight female students denied sexual activity; however, two were found to be pregnant while undergoing therapy.

Incidence of Asymptomatic Bacteruria

The overall prevalence of asymptomatic bacteruria in the seventh grade student population was 2.5%. The prevalence among female seventh grade students was 5.4% and the prevalence among the male students was 0.

Discussion

The results of this screening showed a higher than expected incidence of asymptomatic bacteruria among school girls while confirming its relative rarity among males of the same age. Most studies[6,7] have detected 1% - 2% of school girls as having asymptomatic bacteruria. This study involved the screening of a relatively older junior high school population who were drawn largely from a disadvantaged population. Dodge, *et. al.*,[8] found an emergence of 4.6% in females, by the age of 12, on repeated screening. The community of Robbins in southwest Cook County, Illinois has a population which is 98% black. Its residents have the lowest mean income in the State of Illinois and the highest percentage of residents receiving public assistance. The Posen-Robbins School Health Project, funded by the Robert Wood Johnson Foundation, was located in this community because of multiple demographic parameters indicating severe poverty and unsatisfactory living conditions. These children had not had access to pediatric care in the past. It has been suggested[9] that this type of population might yield a higher percentage of positive results in screening.

The results of this study indicated that the nitrite indicator strip was less accurate than the detection of proteinuria when used as a screening method for asymptomatic bacteruria. Previous studies[10,11] have arrived at the opposite conclusion.

It has been suggested[12] that the treatment of asymptomatic infection may precipitate symptomatic infection by different bacterial species to which the host has not developed "tolerance." This has not been the experience, thus far, among girls found to have asymptomatic bacteruria in this study. All positive cultures among the eight girls with asymptomatic bacteruria in this study grew out *escherichia coli.* During a six-month period of follow-up subsequent to a three week course of sulfisoxazole, four of the patients have had sterile cultures. The other four patients have had persistent or recurrent bacteruria due to E. Coli. It is not known whether the strains of E. Coli causing the infection have changed. All patients have remained asymptomatic, none developed symptomatic urosepsis. Compliance was ascertained by testimony from patients and/or caretakers. It has been quite difficult to achieve satisfactory compliance in extended therapeutic programs because of the lack of symptomatology and the unwillingness of some patients and parents to accept the need for therapy. This tendency has been reported by others.[13] The four patients with persistent or recurrent infection have shown no radiographic evidence of reflux or obstructive uropathy.

Summary

A total of 314 seventh grade students in the Posen-Robbins School Health Project were screened for asymptomatic bacteruria. A multiple dipstick detection method was used for nitrite, glucose, and protein. Where one or more of the dipstick tests was positive, urine cultures were performed on clean voided specimens. A child whose urine culture showed a colony count of greater than 100,000 colonies/ml was defined as having asymptomatic bacteruria. 5.4% of the female students were found to have asymptomatic bacteruria. None of the male students had asymptomatic bacteruria. The percentage of school girls in this age group who demonstrated infection was higher than previously reported. The school population screened in this study was from a poverty area disadvantaged by most demographic parameters ◀

Acknowledgement

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Housestaff News

(Continued from page 390)

pothetical student embarks further, his basic science lecture core may include Medicare/Medicaid policies, cost containment, and medical industrial free market economics. The last already accounts for 10% of the nation's output, according to *U.S. News & World Report* (8/17/81). As the student encounters the clinical years, he may discover a "hands-off" approach to a predominantly private patient population and observe an overworked, inadequately-sized housestaff. Continuity of patient care may be hampered by forced transfer to another institution—if yet extant. Of course, the scenario would be incomplete without headlines regarding the impending dissolution of Social Security trust funds, loss of drug abuse and other assistance programs, abolition of CETA jobs in mental health facilities, and fraud perpetrated by financial crises, as projected by Health/PAC, a New York Health Advocacy organization. Clearly, medicine will face change in the coming months. ISMS must do what it can to assure high quality medical care for the people of our state.

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Case Reports

Left Atrial Myxoma

KANOO M. PATEL, M.D., FRCP(C), FCCP, FACP/GRANITE CITY

A case of left atrial myxoma is presented. The difficulty of a correct diagnosis of myxoma is discussed in terms of the patient's presenting symptoms. The importance of immediate surgical treatment is emphasized.

Myxomas, primary neoplasms probably derived from connective tissue, may be found in any chamber of the heart and constitute half of all cardiac tumors, but nevertheless are rare lesions.[1] Only 5% of the tumors arise in the ventricles.[2] They may resemble an organized mural thrombus and symptoms may include cardiac murmurs that change with alteration of body position. These tumors occur at any age, but most often in women and approximately five times more often in the left atrium.[3] This report describes the diagnosis and successful treatment of a patient who presented with acute left-sided heart failure that was due to myxoma of the left atrium.

Case Report

A 40-year-old woman was seen complaining of "a rattling in the lungs" of six weeks duration, increasing shortness of breath, orthopnea and paroxysmal nocturnal dyspnea. After moderate exertion she suffered localized retrosternal chest pain that was most significant during deep inspiration.

The patient's medical history included a partial hysterectomy one year earlier, but was otherwise unremarkable. She had no history or evidence of rheumatic fever, heart murmur, hypertension, asthma, pneumonia, diabetes or liver disease. She did not use oral contraceptives or other medications and neither smoked cigarettes nor consumed alcohol.

On initial physical examination, bilateral basal rales that extended to the lower axilla were heard on inspiration and expiration. A grade 4/6 hollow systolic heart murmur was heard at the apex but decreased in intensity during late systole, indicating a possible S3 gallop or mid-diastolic rumble. The pulmonary second sound was slightly accentuated although blood pressure was normal. There was intermittent weakness of both femoral pulses.

The patient was admitted to the hospital for further evaluation. Her erythrocyte sedimentation rate (Westergen) was elevated (45) but other routine hematology and chemistry laboratory studies were all within normal limits. Her electrocardiogram revealed sinus tachycardia with left axis deviations and findings suggestive of either right ventricular hypertrophy or nonspecific ST changes.

The chest X-ray showed the patient's heart to be of normal size with interstitial pulmonary edema. A repeat X-ray one week after admission revealed mild cardiomegaly and a slightly enlarged left atrium and right ventricle. The patient was administered digitalis and diuretics. Her condition improved somewhat but she continued to have rales and to suffer from mild to moderate shortness of breath. Her heart failure and murmur persisted.

A phonocardiogram, right and left cardiac catheterization and coronary angiogram were ordered. The findings revealed marked pulmonary hypertension and elevated left atrial pressure. Direct pressure measurements in the left atrium and ventricle indicated presence of a severe obstruction between the left atrium and ventricle. Left atrial angiography revealed a mildly enlarged left atrium and a mid-to-low atrial filling defect which was indicative of a tumor mass. Based upon these findings, diagnosis of left atrial myxoma was considered and the patient was scheduled for cardiac surgery. Before surgery, diagnosis of atrial myxoma was confirmed by echocardiograms.

At surgery, a left atrial myxoma was excised. The maximum diameter of the myxoma was 2.5cms, involved the interatrial septum and filled about 75% of the left atrium. The patient has been clinically asymptomatic with respect to her cardiorespiratory status in the four and one half years since surgery.

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She has had no signs or symptoms or recurrent tumor.

Comment

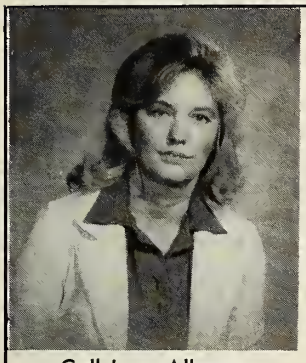
Untreated myxoma will almost always lead to death and timely diagnosis of this uncommon disease is most important. Goodwin's[3] clinical review of 45 patients with proven left atrial myxoma provides a most useful insight into the diagnostic features for those of us who are unlikely to see enough cases to define a specific diagnostic pattern.

Before cardiac catheterization, a provisional diagnosis of mitral valve disease with pulmonary edema was made. Bacterial endocarditis involving the mitral valve and mitral valve disease must be considered in the diagnosis of atrial myxoma. Many of the features common to atrial myxoma are also common to these differential diagnoses, *e.g.*, elevated ESR, variable murmurs, dyspnea.[4] A diagnosis of atrial myxoma should always be considered for middle-aged patients (especially women) who have unexplained heart failure and any constitutional effects with a recent and rapid development and who do not have a history of rheumatic heart disease. The patient described in this report presented with some of these classical features of atrial myxoma. Echocardiography[5,6] can provide an accurate and safe noninvasive diagnosis and should be considered for any patient with the described symptoms.

Since systemic embolization has been reported to occur in 40% of the patients with left atrial myxomas,[4] it is important that treatment (surgery) be instituted without delay. For those patients who make it to surgery and survive the surgery, the prognosis is very good. Although tumor recurrence is rare,[7] regular follow-up is advisable. ◀

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Case Reports

Arsenical Neuropathy

By George Wesbey, M.D. and Arthur Kunis, M.D./
San Francisco and Chicago

Since the time of Hippocrates, the benevolent and malevolent actions of arsenic have given this element a legendary character. It once enjoyed a reputation as a tonic, being consumed by the mountaineers in the Austrian Alps in order to increase strength and endurance.[1] *Its medicinal uses were included in the therapy of syphilis, leukemia, psoriasis, and asthma. Forensic medicine developed around the sinister uses of arsenic, exemplified by the mass homicide practiced by the Borgias's in the 15th century.*[2] *The element's name is derived from the Greek word "arsenikon" ("potent"), and its tastelessness further enhanced arsenic's popularity as a poison.*[3] *Arsenic as a homicidal instrument has declined with the ready availability of chemical identification. Accidental and suicidal intoxication has similarly declined, to the extent that from 1949-1967, only 140 cases of all forms of arsenic poisoning were reported to the National Poison Control Center.*[4] *This case report re-affirms arsenic's modern day neuropathic presence.*

A 79-year-old woman presented with an unsteady gait and a "pins and needles" sensation in her hands of six months' duration. Her legs and feet had been markedly swollen for four weeks. She complained of persistent dropping of objects due to numbness in her hands. The paresthesias were often painful and burning in nature. Her only past history was bilateral cataract extractions. There was no history of any alcohol use, diabetes, or gastrointestinal symptoms.

Physical exam on hospitalization revealed the following abnormalities. There was a warm, erythematous pitting edema of the legs and feet. Sensory perception to pinprick and light touch was significantly diminished in the hands and feet. Hyperpathia was present on gentle stroking of the feet. The muscle stretch reflexes were absent in the ankles and quadriceps. The gait was weak and ataxic. Muscle strength in all extremities was diminished, especially distally. Fine motor co-ordination in the hands was poor.

An SMA-12, CBC, electrolytes, urine analysis, chest X-ray, and EKG were unremarkable. A platelet count, reticulocyte count, serum B_{12}, serum folate, serum protein electrophoresis, multiple blood sugars, auto-antibody panel, T_4, and serum iron and iron binding capacity were all normal. A bone marrow aspirate and biopsy was normal. Cranial computed tomography revealed ventricular dilation and cortical atrophy consistent with the patient's age. An EMG and nerve conduction testing showed very severe slowing in all six nerves examined in the extremities, felt to be compatible with a severe polyneuropathy. A 24 hour heavy metal screen of the urine revealed normal lead and mercury levels. However, an elevated arsenic level (by Gutzeit analysis) of 166μg/L was found (laboratory's normal range less than 100μg/L). There was no consumption of seafood preceding the urine arsenic analysis. She refused further evaluation after improvement in ambulation.



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Patient was re-admitted two months later with the same sensory complaints and an inability to walk. The leg rash and edema were worse, with some hyperpigmentation. Neurologic exam showed the same previous findings, plus a bilateral foot drop. Belligerent and sometimes paranoid behavior were noted. Routine laboratory data were normal. Gutzeit analysis of hair clippings for arsenic was abnormal. The level was 250μg/100 grams of hair (laboratory normal range less than 65μg/100 grams of hair). Insufficient quantities of nails were available for analysis. A 24-hour urinary arsenic level had normalized to 24μ/L. The patient was started on penicillamine, having refused BAL injections. Outpatient compliance with the drug was variable. Nonetheless, a repeat analysis of hair clippings six weeks later showed a normal level of arsenic at less than 10μ/100 grams of hair. The urine arsenic over 24 hours also had further declined, to a level less than 10μ/L. Clinically, her gait and paresthesias has also improved. Despite epidiemiologic and law enforcement investigation, the source of arsenic was never discovered.

Sources of Arsenic

Arsenic is an ubiquitous element. It is the 14th most abundant trace element in sea water, ranks 18th in the universe, 20th in the earth's crust, and 12th in the human body.[5] In only three of 148 sampled U.S. municipal water supplies was arsenic definitely absent.[5] Industrial exposure to inorganic arsenic is vast, with the National Institute of Occupational Safety and Health estimating that 1,500,000 workers in this country are potentially exposed.[6] Examples of industrial exposure are lead and copper smelting, textile printing, herbicide and insecticide manufacturers, paint producers, and wood preservatives.[6] Arsenic can be found in high concentrations in foods, especially seafoods. The U.S. government allows up to 2.6 ppm of arsenic in food, and it is estimated that daily human consumption averages 900μg.[5] Famous epidemics of arsenism have been attributed to arsenic contaminated wine and bread,[7] and beer.[8]

Chemistry and Toxicology

Arsenic is referred to as a metalloid due to its atypical position in the periodic table for a true metal. Most inorganic arsenic can be considered salts of arsenic trioxide(As_2O_3).[7] Generally, the inorganic form is more toxic than organic arsenic,[9] and the trivalent form (As^{+3}) more toxic than pentavalent arsenic (As^{+5}).[10] Trivalent arsenic reversibly combines with the essential sulfhydryl groups of intracellular enzyme systems, especially pyruvate oxidase.[9,10] Arsenic is excreted via the urine, feces, and deposition in hair and nails.[5,11]

Clinical Presentation

Acute arsenic intoxication is characterized by nausea, vomiting, abdominal pain, watery diarrhea, and oropharyngeal burning. Death from circulatory collapse may rapidly ensue.[12]

Repeated ingestion of small doses of arsenic results in chronic intoxication. It is often a diagnostic problem, due to the insidious onset of non-specific symptoms.[13,14] The diagnosis should be suspected in someone who presents with combinations of neuropathy,[7,15] skin rash,[10,12,15] gastrointestinal complaints,[10,12] and hematologic disturbances.[14,16] Renal, hepatic, and cardiovascular manifestations have also been reported. A wealth of epidiemiologic data implicate arsenic as an occupational carcinogen, especially in association with respiratory cancer.[6] Our patient's ankle edema and erythematous dermatitis with areas of hyperpigmentation are a few of the recognized dermatologic manifestations of chronic arsenism.[10,12,15] Other classical manifestations in the skin include hyperkeratosis of the palms and soles,[10] Mee's lines (transverse white striations in the nails),[15] and "raindrop" pigmentation.[10]

The clinical diagnosis of a sensory and motor neuropathy in this patient was evidenced by the numbness, painful paresthesias, gait disorder, muscle weakness, decreased sensory perception, and absent muscle stretch reflexes. The severe nature of the neuropathy was confirmed electrophysiologically. For example, the markedly slowed peroneal motor conduction velocity of this patient (25m/sec) was identical to the mean peroneal motor velocity described in eight patients with arsenical neuropathy.[10] Her distal weakness[7] and "stocking-glove" sensory loss[7,18] are usual findings in arsenic's neuropathy, which usually afflicts both motor and sensory nerve fibers.[10] Hyperpathia is typical, with references in the literature to "walking on fire" due to the "tender-foot ale" in the Manchester arsenic-contaminated beer epidemic of 1900.[19] Both the foot drop[18,19] and loss of lower limb reflexes[10] in this patient are also a feature of arsenical neuropathy. Recovery from neuropathy is often quite slow and incomplete, lasting up to eight years in some cases.[20]

Arsenic's toxicity is not confined to the peripheral nervous system. Possible central nervous system toxicity existed in this patient, with her agitation, paranoid delusions, and mental irritability, all of which have been associated with chronic arsenism.[12,21,46]

Laboratory Diagnosis

Toxicological analysis for arsenic in the urine, hair, and nails is necessary to confirm the clinical suspicion of arsenic intoxication. Several studies have surveyed "non-exposed" populations to determine normal levels of urinary arsenic. Four sources[19,27-29] determined an upper limit of normal ranging from 50-100μg/L in a 24 hour specimen. Seven sources[7,10,16,17,22,24,25] designated the limit as 50μg/L or less. Nine studies found a mean urinary arsenic excretion of under 100μg/L/24 hours.[11,17,24,26,28,30-32,34] This data supports the literature's consensus that abnormal urinary levels of arsenic are greater than 100μg/L/24 hours.[24,35-37] This patient's level of 166μg/L was consistent with many reported cases of arsenic intoxication in the literature,[15,16,31,38] including cases of arsenical neuropathy.[7,19,20]

Similarly, ten sources[5,7,10,14,15,18,39-41,43] assigned an upper limit of normal of arsenic in hair ranging from 50-100μg/100 grams of hair. Four sources[19,22,23,42] designated the upper limit as 50μg/100 grams of hair. The mean level of normal was considered less than 100μg/100 grams of hair in eight sources.[30,33,35,41,44-47] Again, this data supports the literature's con-

sensus that hair arsenic levels over 100μg/100 grams are abnormal.[19,20,24,35] This patient's level of 250μg/100 grams of hair is consistent with other reported cases of arsenical neuropathy.[10,19] No evidence was discovered for external contamination of the hair by arsenic.

Estimating the timing and extent of this patient's arsenic exposure is difficult. Her paresthesias had historically begun six months before the first hospitalization. It is conceivable that the timing of the exposure was well over six months prior to the first admission. The number of exposures is impossible to ascertain. Neuropathy can occur months after a single exposure to arsenic that was originally insufficient to merit medical attention.[20] Arsenic can be present in elevated quantities in the hair long after urinary excretion has ceased.[6,12,24] This was the case during the patient's second hospitalization.

Differential Diagnosis

The major differntial diagnosis in arsenical neuropathy is that of alcoholic neuropathy, since arsenism and alcoholism can often co-exist (the best example being the Manchester arsenic-beer epidemic). Arsenic's neuropathy is faster to develop than alcohol's,[46] and it afflicts the motor system earlier.[19] Diabetic neuropathy often presents with distal weakness and pain, similar to arsenic's distal symptoms.[7] Guillan-Barre syndrome rarely has such pronounced sensory symptoms and has more frequent cranial nerve involvement.[10,19] Acute intermittent porphyria presents with a primarily motor neuropathy and abdominal pain. Other heavy metal neuropathies due to lead, mercury, or thallium should be ruled out.[7] Exposure to numerous toxic solvents or insecticides should be considered.[19]

Therapy

The treatment of acute arsenic intoxication is generally more satisfactory than that of chronic arsenism. Chelation with BAL (Dimercaprol) within hours of acute intoxication has been found to be effective,[10] especially in preventing neuropathy.[19] However, if chelation is delayed beyond 24 hours after acute exposure, prevention or alleviation of neuropathy is unlikely.[19] Goldstein, *et. al.*,[7] did not see any superiority of BAL over penicillamine in arsenical neuropathy and preferred use of the latter drug. The use of penicillamine in acute arsenic intoxication has also been described.[25]

Conclusion

The value of the heavy metal screen of the urine in the workup of peripheral neuropathy is illustrated in this case report. If a heavy metal toxic etiology is found, the optimal therapy is removal of the patient from ongoing toxin exposure.

Acknowledgement

The authors wish to thank I. Lipman, M.D., M. Horowitz, M.D., and H. Slavick, M.D. for their neurologic evaluation of the patient. The assistance of Richard Lozoff, M.D., is also appreciated.

References

A complete list of references for "Arsenical Neuropathy," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

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Viewbox

(Continued from page 291)

Answers

Figure 1-B
Figure 2-C
Figure 3-D
Figure 4-A

Ultrasound (US) of the gallbladder is a firmly established and well documented diagnostic procedure. The overall accuracy of cholecystosonography is 96% in the most recent studies with sensitivity ranging between 91 and 96% and specificity ranging between 94 and 99%.[3,4,14,16,20,24] These figures were obtained with real time ultrasound equipment, which appears to give better results than the conventional static gray scale instrument.[16,24] Studies that compare US with oral cholecystography (OCG) may show from two to four percentage points in favor of one procedure or the other depending on the particular institution, but for all practical purposes when both US and OCG are performed meticulously they can be considered equal in accuracy.[16]

The ultrasound examination is ideally performed after a six to eight hour fast when the gallbladder is physiologically distended. A complete examination with real time ultrasound takes less than 10 minutes. Advantages of US are same day examination, speed, lack of radiation, and independence from intestinal absorption of iodinated compounds. Diagnostic quality sonograms are obtained in 96 to 99% of patients.[3,7,14,16,20,24] Uncommon technical failures are usually due to anatomic variations in the position of the gallbladder and the presence of skin wounds over the gallbladder area. US does not evaluate bile excretion or concentrating ability of the gallbladder.

The majority of requests for cholecystosonography are to "rule out gallstones." Positive findings can be divided into four categories.[20] Group 1: *One or more echoes within the gallbladder which produce an acoustic shadow* (Figure 1,2,3). Stones that are not impacted drop rapidly to the dependent portion of the gallbladder following a change in patient position. When these criteria are fulfilled, the diagnosis of gallstones is virtually 100% accurate.[4,20] All stones over 3mm in diameter should shadow.[1] Smaller size stones may or may not shadow.[2] Intrinsic ultrasonic attenuation is important in determining the degree of shadowing.[22] More highly attenuating stones have a high percentage of crystalline material and a larger crystal size.[22] The highest frequency transducers available should be used to maximize shadowing.[1, 22] Shadowing does not appear to be related to calcium content, shape, surface characteristics or specific gravity of the stone.[1]

Group 2: *There is acoustic shadowing from the area of the gallbladder without visualizing the gallbladder.* This finding has been associated with stones in a contracted gallbladder in 88-98% of patients.[4,12,20]

Group 3: *There are one or more discrete non-shadowing echoes less than 5mm in diameter which may move with gravity.*[20] Eighty-one percent of patients in one study with these findings had gallstones.[2] Immobile, non-shadowing echoes in another study turned out to be polyps in 100% of patients.[20]

Group 4: *Small, low level non-shadowing echoes within the gallbladder which form a fluid-fluid level.* The incidence of stones in this group has been reported as 8%, 61%, and 69%.[4,20,26] The statistics indicate that in many patients this echo pattern may be due to particulate matter other than tiny stones. The differential diagnosis includes tiny stones, "sludge" (Fig. 2), pus (Fig. 3) and cholesterol crystals.[2] Thick bile or sludge classically moves slowly (minutes) with positional change.[2] This is not a hard and fast rule, however, since sludge can also move rapidly and be indistinguishable from the other entities which move rapidly.[2] It has been shown experimentally and verified clinically that cholesterol crystals do produce non-shadowing echoes that form a fluid-fluid level.[2,9] Filly and associates demonstrated by graded filtration that the major echo producing components of sludge are pigment granules (calcium bilirubinate) and to a lesser extent, cholesterol crystals.[6] There is a strong correlation between gallbladder disease and the presence of sludge.[6] This finding can also be seen in prolonged fasting, jaundice, hepatitis, hemolytic disease, and pancreatic disease in the absence of gallbladder disease.[6] Layered, non-shadowing echoes within the gallbladder are abnormal,[4,6] When these echoes move slowly they are termed "sludge". Clinical correlation is required to identify patients without gallbladder disease. Fast moving echoes can be due to sludge, stones, or pus.

Cholecystosonography is often ordered to rule out cholecystitis. Acute cholecystitis is present only in 13-34% of patients presenting with right upper quadrant pain and tenderness.[17] Thickening of the gallbladder wall may be seen in addition to gallstones.[5,7,11,12,15,17,19,21] Normally the gallbladder wall measures 1-2mm thick. Most authors use the upper limits of normal as 3 mm.[5,7,8,12] An occasional "normal" gallbladder wall may be more than 3 mm thick. A sonolucent area (edema) within the thickest part of the wall (Fig. 3) can be seen in some cases of cholecystitis.[19] Besides acute cholecystitis a thickened gallbladder wall can be seen in chronic cholecystitis, hepatitis, hypoproteinemia, heart failure, and renal disease.[8,18,23,25] Patients with acute and chronic cholecystitis may not have a sonographically thickened wall.[5]

Carcinoma of the gallbladder can have four sonographic appearances: tumor mass filling the gallbladder, thickened gallbladder wall (Figure 4), mass of the wall of the gallbladder, and mass plus wall thickening.[29,30] A thickened gallbladder wall can also be seen with acute and chronic cholecystitis. It is understandable that carcinoma of the gallbladder can be overlooked when there are gallstones present. In our experience, wall thickening is more irregular in carcinoma of the gallbladder than in inflammatory disease. Early carcinoma of the gallbladder can also appear as a solitary, non-shadowing mass on the gallbladder wall.[29,30] This diagnosis is difficult to make since cholesterol polyps, mucosal hyperplasia, inflammatory polyps, adenoma, papilloma, and lipoma can look the same.[29] The diagnosis is easier to make when the entire gallbladder is filled with tumor or there is adjacent invasion of the liver.

Ultrasound of the gallbladder is an accepted screening method for examining the gallbladder particularly when in-patients are NPO for various reasons. Equivocal examinations can be referred for OCG. It is also desirable to employ US in emergency cases because of the speed and ease of the examination. Cholescintigraphy can be employed to determine if the cystic duct is patent when a patient suspected of having acute cholecystitus does not have stones by sonography. ◀

References

A complete list of references for this month's Viewbox may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago 60603.



Lung cancer is now an equal opportunity tragedy.

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U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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EKG

(Continued from page 284)

Answers: 1. C, D 2. B, C, D

The twelve lead ECG shows a sinus rhythm with a rate of sixty beats per minute, marked non-specific ST-T wave changes and a prolonged Q-T interval. The Q-T interval measures 0.60 seconds and the T waves are inverted in leads I and AVL. The PR interval and QRS duration are normal. With this history in a patient this age, a central nervous system event would be a more likely diagnosis. Both rhythm disturbances and repolarization abnormalities have been associated with acute cerebral disorders: subarachnoid hemorrhage, subdural hematoma, intracranial hemorrhage, and cerebral thrombosis or embolus. The most dramatic ECG abnormalities occur with subarchnoid or spontaneous intracranial hemorrhages. ST-T wave changes can be markedly abnormal and resemble the changes seen in ischemic myocardial disease. Thus, in an older patient, a reasonable differential diagnosis would include myocardial infarction. The ECG abnormalities noted in central nervous system disease are large, wide T waves, ST segment shifts, prolonged Q-T intervals, and prominent U waves. The exact mechanism of these ECG changes is unknown. Alterations in sympathetic tone have been suggested as the etiology. This was based on animal studies where a unilateral stellate ganglionectomy seemed to cause comparable repolarization changes on the ECG. These changes in Q-T interval or ventricular recovery time could reflect changes in the functional refractory period and make the heart more vulnerable to re-entrant arrhythmias. For more information on this interesting area see J. A. Abildskov "Central Nervous System Influences Upon ECG Waveforms", Chapter 19 in Volume 2, ADVANCES IN ELECTROCARDIOGRAPHY Schlant and Hurst, Eds. Grune and Stratton, New York, 1976. ◀

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Original articles will be considered for publication with the understanding that they are contributed only to the *Illinois Medical Journal.* The *Journal* assumes no responsibility for the opinions and claims expressed in the articles contributed. All should include an abstract.

Review articles should not exceed 12 to 16 pages. Case histories are also accepted; these should be limited to a maximum of 8 pages. Up to 20 references will be published for review articles and up to 10 will be published for case histories.

Manuscripts should be typed, double spaced, and submitted in duplicate. Illustrations must be in black and white; positives of photographs are preferred. They should be addressed to: *Illinois Medical Journal,* 55 E. Monroe, Suite 3510, Chicago, IL 60603.

References should be numbered in order of appearance in the text and conform to the following style *and order:* Name of author, title of article, name of periodical with volume, page, month (day of month if weekly) and year. The *Journal* does not assume responsibility for the accuracy of references used with articles.

The first page should list the title, the name of the author(s), degrees and any institutional or other credits as well as the author's mailing address. The title should be as short as possible. Pages should be numbered consecutively. Tables are to be typed, numbered and accompanied by a brief descriptive title. Photographs should be marked "top" and the back of each should identify the article accompanying them. Number illustrations consecutively and indicate their place in the text.

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Guide to Continuing Medical Education

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Items for this Calendar must be received 90 days prior to the event. Those received earlier may appear in up to three monthly issues.

If your organization's CME activities are not listed—please contact us. To avoid possible conflicts, you're invited also to consult our file of future events. Individual physicians may also call or write for information about CME programs scheduled for dates later than those covered here.

DECEMBER

Cardialogy

Clinical Management of Coronary Disease & Exercise Testing
For: FP's, GP's, Internists. Seminar, Dec. 4-5, Hyatt Regency, Chicago. **Sponsor:** International Medical Education Corp., 64 Inverness Dr. E., Englewood, CO 80112. **Reg. deadline:** none. **Fee:** $245. **Reg. limit:** 85. **Credit:** Category 1, 13 hours; AAFP Prescribed, 13 hours; AOA, 13 hours. **Contact:** Stephen Mattingly. **Phone:** 800-525-8651 x 123.

Emergency Medicine

Pulmonary Problems for Emergency Physicians
For: MD's. Symposium, December 9, St Louis, MO. **Sponsor:** St. Louis University, School of Medicine, 1402 S. Grand, St. Louis, MO 63104. **Fee:** $75, MD; $25, in-training. **Reg. limit:** none. **Credit:** Category 1, 7 hours. **Contact:** John Grellner. **Phone:** 314/664-9800 x 127.

Family Medicine

Coronary Artery Disease—The View in 1981
For: Primary Care Physicians. Symposium, December 11-12, Madison, WI. **Sponsor:** U of W-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** $135. **Reg. limit:** none. **Credit:** Category 1, 12 hours; AAFP Prescribed, 12 hours; AOA, 12 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Internal Medicine

Current Concepts in Cancer Therapy
For: MD's. Seminar, Dec. 10-12, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $275. **Reg. limit:** 500. **Credit:** Category 1, 19 hours; AAFP Prescribed, 19 hours; AOA, 19 hours; AMRA. **Contact:** Loretta Giacoletto. **Phone:** 314/454-3873.

Internal Medicine

Fluid & Electrolyte Balance, Hypertension & Renal Disease
For: MD's. Course, Dec. 9-11, Chicago. **Sponsor:** American College of Physicians, Postgraduate Dept., 4200 Pine St., Philadelphia, PA 19104. **Fee:** $225, members; $170, associate; $300, non-members. **Credit:** Category 1, 20½ hours. **Contact:** Maxine Topping. **Phone:** 800-523-1546.

Medicine

Neurology
For: MD's. Symposium, Dec. 3, 1:00 p.m., Robinson. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Ears, Nose and Throat
For: MD's. Symposium, Dec. 3, 1:00 p.m., Jacksonville. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Arthritis
For: MD's. Symposium, Dec. 3, 1:00 p.m., Chester. **Sponsor:** SIU School of Medicine, 801 N. Rutledge, Rm. 4241, Springfield 62708. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Medicine

Calcium Channel Blockers
For: MD's. Symposium, December 2, Springfield. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Nephralogy

Fluid and Electrolyte Balance, Hypertension and Renal Disease
For: Internists, GP's. Workshop/course, Dec. 9-11, Chicago. **Sponsor:** American College of Physicians, 4200 Pine St., Philadelphia, PA 19104. **Cosponsors:** Northwestern University Medical School; Northwestern Memorial Hospital. **Fee:** $225, member; $170, associate; $300, non-members. **Reg. limit:** 120. **Credit:** Category 1. **Contact:** Maxine Topping. **Phone:** 215/243-1200.

Neurology

Neurology for the Non-Neurologist
For: Internists, FP's. GP's. Psychiatrists. Course, December 9-11, Chicago Marriott Hotel. **Sponsor:** Rush-Presbyterian-St. Luke's Medical Center, CME, 600 S. Paulina, Chicago 60612. **Fee:** $315. **Reg. limit:** 150. **Credit:** Category 1, 20 hours. **Contact:** Barbara Trejo. **Phone:** 312/942-7095.

OB/GYN

OB/GYN
For: MD's. Symposium, December 10, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

OB/GYNE

Problem Solving in Gynecologic Endocrinology and Infertility
For: Ob/Gyn. Lecture/discussion, December 4-5, Chicago. **Sponsor:** The University of Chicago, CME, 950 E. 59th St., Box 139, Chicago 60637. **Fee:** $195; $75, residents. **Credit:** Category 1, 13 hours; ACOG. **Contact:** M. A. Dillon. **Phone:** 312/947-7084.

Ophthalmalogy

Clinical Conference
For: Ophthalmologists. Rounds, Dec. 2, 9, 16 & 23, 4:00-6:00 p.m., Chicago. **Sponsor:** Dept. of Ophthalmology, U of I, 1855 Taylor, Chicago 60612. **Credit:** Category 1, 2 hours. **Contact:** Jacob Wilensky, MD. **Phone:** 312/996-7030.

Orthopedic Surgery

Procedures Useful in Evaluating & Treating Low Back Pain & Sciatica Pain
For: MD's. Symposium, Dec. 5, St. Louis, MO. **Sponsor:** CME, Washington University School of Medicine, Box 8063, 660 S. Euclid, St. Louis, MO 63110. **Fee:** $75. **Reg. limit:** 150. **Credit:** Category 1, 7 hours; AOA, 7 hours; AAFP Prescribed, 7 hours. **Contact:** Loretta Giacoletto. **Phone:** 314/454-3873.

Psychiatry

DSM III—Advanced Clinical Symposium
For: Psychiatrists, Psychologists. Symposium, December 14, Edgewater Hotel, Madison, WI. **Speakers:** Robert Spitzer, MD; Janet Williams, MSW. **Sponsor:** U of Wisconsin-Extension, CME, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** $90. **Reg. limit:** none. **Credit:** Category 1, 6 hours. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Radialagy

Contrast Media: Application, Problems and Reactions
For: MD's. Lecture, Dec. 4, 3:00 p.m., North Chicago. **Speaker:** Vlastimil Capek, MD. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Radialagy

CT Scanning of the Brain: Interesting Case Studies
For: MD's. Lecture, Dec. 11, 3:00 p.m., North Chicago. **Speaker:** Ruth Ramsey, MD. **Sponsor:** University of Health Sciences/The Chicago Medical School, 3333 Green Bay Rd., North Chicago 60064. **Credit:** Category 1, 1 hour. **Contact:** Ben Blivaiss, PhD. **Phone:** 312/578-3215.

Surgery

Specialty Review in Thoracic Surgery, Part I
For: General and Cardiothoracic Surgeons. Lecture, Dec. 7 (5 days), Chicago. **Speaker:** Sidney Levitsky, MD. **Sponsor:** Cook County Graduate School of Medicine, 707 S. Wood St., Chicago 60612. **Fee:** $425. **Reg. limit:** 200. **Credit:** Category 1, 45 hours. **Contact:** Robert Baker, MD. **Phone:** 312/733-2800.

JANUARY

Endocrinalogy

Symposium on Endocrinology
For: MD's Symposium, January 8, 15, 22 and 29, 11:00 a.m., Oak Park. **Sponsor:** Oak Park Hospital, 520 S. Maple Ave., Oak Park. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 4 hours. **Contact:** Charles Weigel, MD. **Phone:** 312/366-7870.

Family Medicine

Current Use of Estrogens
For: MD's. Lecture, January 20, DuPage County. **Speaker:** William Spellacy, MD. **Sponsor:** DuPage County Medical Society, 26 W. St. Charles Rd., Lombard 60148. **Reg. deadline:** 1/15. **Fee:** none. **Reg. limit:** none. **Credit:** Category 1, 2 hours; AAFP Elective. **Contact:** Lillian Widmer.

Genetics

Clinical Genetics
For: Primary Care Physicians. Lectures/workshops, January 22-23, Madison, WI. **Sponsor:** CME, University of Wisconsin, 465B WARF Bldg., 610 Walnut St., Madison, WI 53706. **Reg. deadline:** none. **Fee:** TBA. **Reg. limit:** none. **Credit:** TBA. **Contact:** Sarah Aslakson. **Phone:** 608/263-2856.

Internal Medicine

New Therapeutics II: The Results of Recent Advances in Medicine
For: FP's, Internists. Symposium, Jan. 18-20, Telemark Lodge, Cable, WI. **Sponsor:** U of Wisconsin School of Medicine, CME, 610 Walnut St., Rm. 454, Madison, WI 53706. **Fee:** $215. **Credit:** Category 1, 14 hours; AAFP Prescribed, 14 hours. **Contact:** Ann Bailey. **Phone:** 608/263-2854.

Medicine

Cardiology Pharmacology
For: MD's. Symposium, January 21, 1:00 p.m., Lincoln. **Sponsor:** SIU School of Medicine, CME, P. O. Box 3926, Springfield 62708. **Credit:** Category 1, 4 hours. **Contact:** Lorraine Stephenson. **Phone:** 217/782-7711.

Doctor's News

PHYSICIANS IN THE NEWS—**Marshall Falk, M.D.,** Chicago, has been appointed to serve on the Illinois Hospital Licensing Board and also elected president of the Illinois Council of Medical School Deans. . . . **Patrick Staunton, M.D.,** Park Ridge, has been named to the Illinois Guardianship and Mental Health Advocacy Commission. . . . **Frank W. Newell, M.D.,** Chicago, has been elected president of the National Society to Prevent Blindness. Dr. Newell is editor-in-chief of the American Journal of Ophthalmology and a professor at the University of Chicago.

Newly named officers of the Chicago Society of Plastic Surgery are **Richard L. Sperling, M.D.,** Skokie, president; **Norman E. Hugo, M.D.,** Chicago, vice president; **Randall E. McNally, M.D.,** Chicago, secretary and **Raymond L. Warpeha, M.D.,** Maywood, treasurer.

Gurnee cardiologist **Tien Chu Cheng, M.D.,** who writes on health matters for the Waukegan "News-Sun," recently published a guidebook for the heart attack victim entitled "The Heart of the Matter."

Sandor Berendi, M.D., Chicago, recently received a citation for his work as a Social Security Administration Regional Commissioner. . . . Newly named fellows of the American College of Radiology include **Jen-hung Chao, M.D.,** Chicago and **Richard L. Phillips, M.D.,** Park Ridge.

Recently announced officers of the Chicago Pathology Society are **Martin A. Swerdlow, M.D.,** Chicago, president; **Hartmann Friederici, M.D.,** Evanston, vice president; **Marshall H. Short, M.D.,** Chicago, secretary, **Wellington Jao, M.D.,** Chicago, treasurer and **John G. Gruhn, M.D.,** Chicago, program director. **M. Eugene Tardy, Jr., M.D.,** Chicago, has been named president-elect of the American Academy of Facial Plastic and Reconstructive Surgery.

PNEUMOCOCCAL VACCINE COVERED—AMA notes that Medicare beneficiaries will be notified by the government that pneumococcal vaccine is covered for federal reimbursement. The Health Care Financing Administration has announced that all Medicare recipients will be so informed late this year, and Medicaid beneficiaries will be encouraged to consult personal physicians for additional information about receiving the vaccine.

MEDICAL QUACKERY is the subject of a new brochure published by the Federal Postal Inspection Service. According to an AMA summary "Do You Believe in Magic?" cites four warnings: "Don't trust your health to a salesman; don't believe claims of a secret cure or miracle drug; don't believe claims of excessive weight loss; don't believe exaggerated claims of regained youth or the perfect figure." Copies of the brochure may be obtained by writing: Chief Postal Inspector, Consumer Protection Program, Washington, D.C., 20260.

U.S. INFANT MORTALITY RATE DROPS—The twelve month period ending May, 1981, shows the nation's infant mortality rate was 12.3 per 1,000 live births—decreased from 12.8 in the previous annual period. National Center for Health Statistics reports further showed that the June, 1981, monthly rate was lower yet—11.2 per 1,000 live births.

DRUG ABUSE MANUAL AVAILABLE—A new AMA book designed to help physicians treat patients with drug problems is now available. DRUG ABUSE: A GUIDE FOR THE PRIMARY CARE PHYSICIAN, considers incidence, treatment and confrontation skills in dealing with drug abusers. Prescribing practices that curb abuse of prescription drugs are also considered. The book also gives a guide to chemical, proprietary and slang names of common drugs of abuse, and signs and symptoms of drug abuse. Copies are available at a cost of $17 by writing the Order Dept., OP-323, AMA, P.O. Box 821, Monroe, WI 53566.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

AURORA: Population 85,000-opening for cardiologist in well-established group of 45 physicians. Excellent hospital and clinic space available. Located 50 miles from downtown Chicago on E/W Tollway. CONTACT: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506 (312-859-6700). (12)

CARBONDALE: Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. CONTACT: George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351). (4)

CENTRAL ILLINOIS: Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. Contact: Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

CLIFTON: Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

CLINTON, IA: Internist (with/without subspecialty), Surgeon, OB-GYN, and ENT physicians are needed in Clinton. Multi-specialty group serving large part of Western Illinois. Excellent opportunity for quality care, professional interaction with friendly colleagues and financial security. Contact Dr. Daniel J. Baxter, collect: 319-243-4600 days or 319-242-6451 nights. (2)

DU QUOIN: Opportunities for solo or group practice in well known small community. St. Louis 75 miles. S.I.U.-Carbondale 25 miles. Excellent schools, churches, shopping, housing and recreation. JCAH hospital specializing in quality care. Du Quoin and Marshall Browning Hospital would love to tell you more. Call David R. Hosler, Adm., collect at 618-542-2146. (12)

FAIRBURY: Family Practice Physician to join fast growing practice in thriving rural area. Well-equipped, JCAH accredited, 112-bed hospital offers income guarantees and other financial assistance. Send Curriculum Vitae in confidence to Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (12)

FAIRBURY: Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. Contact: Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

FRANKFORT: Multispecialty group seeks young family physician, willing to do OB and also seeking OB-GYN—to join expanding practice, which is located some thirty miles southwest of Chicago. Incentive plan, profit sharing; as well as a new building. Excellent practice opportunities. CONTACT: Howard Osmus, Administrator, Hedges Clinic, Frankfort 60423 (815-469-2123). (1)

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REPORT
FOR Illinois Physicians

More Than 1,000 Persons Attend Illinois Blue Cross and Blue Shield Symposium

A standing-room only crowd of more than 1,000 persons attended the Illinois Blue Cross and Blue Shield Plan's Sixth Annual Health Care Symposium, held at the Hyatt Regency Chicago Hotel in late October.

A flurry of bold concepts on the "industrialization" of health delivery, plus the anticipated tug-of-war between Reagonomists and Democrats were discussed during the day-long meeting. There also were appeals for "The Little Guy" from the widow of Dr. Martin Luther King, Jr. and for better consumer tools by the Administration's consumer director, Virginia Knauer.

A controversial study prepared by the Health, Education and Welfare's Graduate Medical Education and National Advisory Committee (GMENAC) was the source of some of the first surprises of the day.

Dr. Alvin Tarlov, University of Chicago professor of medicine and chairman of the GMENAC panel, attracted attention from the predominately health care—related audience with his assertion that a national surplus of physicians will force doctors to resume making house calls as competition for patients drives health professionals into the farthest limits of service marketing techniques.

Among his satchel full of shocks, Dr. Tarlov said young doctors eager for basic financial security in this tight economy are looking favorably toward working in the military, in prisons, and on the staffs of health maintenance organizations (which he admitted is an attitudinal switch).

Two-Doctor Families in Vogue

According to the graduate of Dartmouth and U. of C. Medical School, patients are already shifting from the single-family-physician concept to two or more physicians—and they are doing so without the knowledge of any of the doctors involved, indicating that the days of the omnipotent, grandfather-styled family doctor are gone.

Dr. Tarlov said the origins of the growing surplus of physicians could be directly attributed to the civil rights movement of the 1950's, "especially that era following the Supreme Court (desegregation) decision."

In the 10 years following that decision, the nation's health priorities were established, and a principle was enunciated which stated that "equal access to high quality health services at an affordable cost for all Americans is a fundamental right of citizenship."

"The nation," he continued, "fulfilling its promise, and as expressed in the Medicare and Medicaid legislation, perceived in the late 1960's that a shortage of physicians would imperil fulfillment of the national dream.

"As a result of that perception, strong initiatives were taken at the local, state, federal, and private levels to increase the numbers of doctors largely through an expansion of class size and the development of new medical schools, particularly under state auspices.

Entering Med Classes Hit 20,000

"As a result of those initiatives, expansion of the entering class size occurred in the 1970s from approximately 8,000 in the late 1960's to an entering class of almost 20,000 today."

While the number of physicians is increasing, Dr. Tarlov noted also that "the rate of increase of other health providers may be even greater."

In these catagories he included nurse practitioners, nurse clinicians, physicians' assistants, optometrists, psychologists, and psychiatric social workers.

The 40 percent increase in physicians will, in Dr. Tarlov's projection of the 1980 decade, create a higher physician-to-population ratio, with improved geographic distribution as well as improved access to health care services.

It will produce a supply of practical, salaried physicians as mentioned earlier.

There will be a very large increase in intra- and inter-professional competition," he declared, putting the general physician in competition with the specialist (meaning that neither doctor will refer a patient to the other's office.)

Doctors will form one-stop, full-service partnership practices and compete directly against nearby hospitals, he added, building emergency centers, primary care centers, as well as birthing and surgical facilities.

They'll see a shift in the doctor/patient relationship also, Dr. Tarlov revealed, when the "trust which has dominated for almost 2,000 years is replaced by a contractual relationship.

"In that contract, the rights to health services previously purchased under contract with (an insurance) corporation will be expected and will replace the trusting relationship."

His economic forecast included a higher utilization rate of doctor's services per capita, netting a higher overall cost to the health care system.

Hospitals will move away from government ownership in the public sector, he said, away from governing regulations, and "away from the not-for-profit concept to an industry in which not-for-profit and profit multihospital systems will compete."

Schools Decrease Class Size

Just this past September, Dr. Tarlov stated, medical schools began responding to the increase in the physician's surplus by decreasing class sizes. While the schools are receiving less government support, leading to increases in tuition and students' indebtedness, the fallout is that "the socioeconomic and cultural background of individuals who selected medicine for their futures will undergo further erosion in a direction which is contrary to national health policy."

Addressing the massive influx of medical providers from outside the United States, he said: "In the teaching hospitals, there will be increasing pressures to decrease the entry of alien physicians to their medical staff either for training or for full hospital privileges," and added "There will be enormous pressures on the teaching hospitals to impede the entrance of U.S. citizen graduates of medical schools in the Carribean and Mexico for training and practice."

Dr. Tarlov warned his audience that "I have not placed a (moral) value on any of these individual effects...Judgements, positive or negative, are variable, depending on individual perspectives.

"It is clear, however, that all of us are going to have to reconceptualize our business."

Institutions To Restructure

The president of the nation's largest multi-unit hospital system, Edward Connors, told the crowd that he foresees a restructuring phenomenon from independent to multi-unit institutions.

Connors, president of the Sisters of Mercy Health Corporation, said that by 1990, the shift from independent to multi-unit hospitals would rise from the current 35 percent to 50 percent.

Citing what he contends is premature criticism of the corporate-oriented shift, Connors said there has been too little dialogue between major components in the health care delivery systems.

Multi-unit systems will grow and diversify, Connors declared, noting that both profit-making institutions and providers whose emphasis is primarily the delivery of community health services can expect huge benefits in the outcome.

One of the ways Connors said multi-unit systems will out-perform independent hospitals is with their management clout—administrators with broader business contacts.

"Private business and public service proponents need not necessarily be at odds about health service values," he said, because neither can be a pure entity. Each system has to adopt some of the values and policies of the other.

Momentum Helps Growths

Finally, Connors said, the entire industry must continue its forward momentum, because "momentum enables an organization to grow, adapt and productively pursue the future."

During the afternoon segment, Dr. Eugene McCarthy, clinical professor of public health at Cornell University Medical College, addressed the audience, echoing some of Dr. Tarlov's remarks.

McCarthy cited recent studies indicating that increasing numbers of health care practitioners have resulted in increasing utilization of health care services.

"Until 1970," he stated, "our index of key surgical operations showed that the number of operations increased in direct proportion of the rise in population. Since then, the number of operations has shown increases four to five times greater than the population increase."

Mandatory Second Opinion Urged

He advocated mandatory second opinions on elective surgery, and defended it as cost-effective.

"Our study of one million persons with mandatory second opinion coverage showed an average of 18 percent no-confirmation for the six key operations. This average was much higher in the OB-gynecology and orthopedic areas. We found that the cost-benefit ratio of these cases was 2.4 to 1; that is: $2.60 saved on surgical costs for every $1 spent on second opinions."

Dr. McCarthy also noted that a significant minority of surgeons are now practicing "opportunity pricing" of their services, to take advantage of the rising number of Americans with double health coverage.

Reporting on yet another program, he said surgeons involved in 14,000 operations were asked to lower their fees voluntarily. "All we did was call them on the phone and ask. Believe it or not, 80 percent did so," he declared.

He concluded: "While these projects aren't the whole answer to health care cost containment, they could make a significant dent if implemented nationwide."

REMINDER

As of December 14, 1981, the new Physician Hot-Line number within the '312' area code will be *938-7340*. The toll free number for area codes other than '312' will remain the same (800-972-8088). Please remember that these lines were installed to provide a service to you; Do not give these numbers to your patients.

The new telephone number for the general public will be *938-7500*.

Your Professional Relations Representative's new telephone numbers are:

Sandra Konnis	938-7880
Richard Quigley	938-7884
William R. Livingston	938-7885
Professional Relations Department	938-7060

(This report is a service to the physicians of Illinois)

IMJ

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December 1981
(USPS 258-160)

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Microfilm copies of current as well as some back issues of the *Illinois Medical Journal* may be purchased from Xerox University Microfilm, 300 North Zeeb Road, Ann Arbor, Mich. 48106.

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Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

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Abstracts of Action

November 6-8, 1981

Springfield Hilton
Springfield

These abstracts are published so that members of the Illinois State Medical Society may keep advised of the actions of the Board of Trustees. They cover only major actions and are not intended as a detailed report. Full minutes of the meetings are available for review upon any member's request to the headquarters office of the ISMS.

ESSENTIALS FOR ACCREDITATION OF CME SPONSORS

The Board of Trustees adopted a five-page statement on ACCME's *Essentials for the Accreditation of Sponsors of Continuing Medical Education (Draft II)* and its rules, regulations and procedures. The statement—proposed by the Committee on CME Accreditation and modified in accordance with amendments offered by the Chicago Medical Society—will be forwarded to ACCME, the AMA representatives to ACCME and the AMA Council on Medical Education.

While ACCME adopted the *Essentials* last June, ACCME bylaws provide that each member organization (AMA, AHA, CMSS, etc) has 180 days in which to approve the adoption or take another action. It is anticipated that the AMA Council on Medical Education will offer a recommendation for action by the AMA House of Delegates at its 1981 Interim Meeting in December.

SYMPOSIUM ON ALLIED HEALTH PROFESSIONALS

ISMS will sponsor a Symposium on Allied Health Professions, Saturday, Feb. 13, at Southern Illinois University School of Medicine in Springfield. Its theme: *Comprehensive Care—Who Does What Best?*

A registration fee of $40 was established, with attendance limited to 130. Purpose of the seminar will be to help members of the health care team develop an understanding and appreciation of each other's role. Category II CME credit will be offered.

The program will be presented in cooperation with the Illinois Council on Continuing Medical Education and Southern Illinois University School of Medicine.

REDUCED REGISTRATION FEES FOR STUDENTS, RESIDENTS

The Board agreed that—when ISMS is the sole sponsor of a workshop or seminar for which a registration fee is charged—the fee will be eliminated or substantially reduced for medical student and resident members of the Society contingent upon available space allocations.

'DO NOT RESUSCITATE' ORDERS

The Board will notify the membership through the *Illinois Medical Journal* that—if a "Do Not Resuscitate" order is given—it must be written on the order sheet in keeping with JCAH requirements. The Medical Legal Council was requested to develop guidelines for the writing of DNR orders.

(Continued on page 452)

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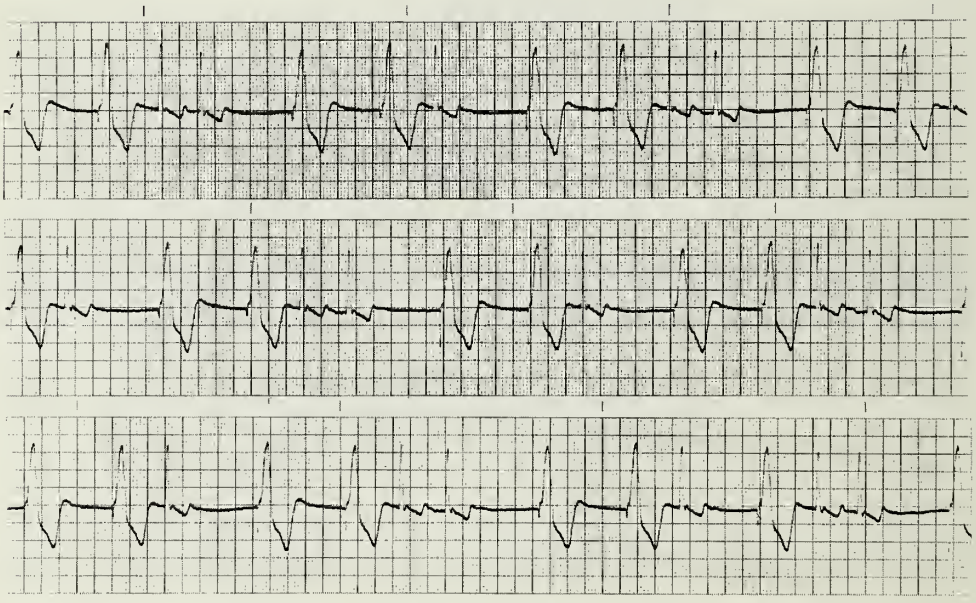
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EKG of the Month

Contributing Editors: John F. Moron, M.S., M.D., David J. Hale, M.D., Patrick J. Scanlon, M.D., Sarah A. Johnson, M.D., John R. Tobin, M.S., M.D., and Rolf M. Gunnar, M.S., M.D., Section of Cardiology, Department of Medicine, Loyola University Stritch School of Medicine

This is a sixty-eight year old man who presented for evaluation of progressive dyspnea on exertion, occasional paroxysmal nocturnal dyspnea, and more recently, some lightheadedness. He denied any chest pains or previous cardiac history. Physical examination of the heart demonstrated a single second sound, and a grade 4/6 crescendo systolic murmur. The murmur was loudest at the base of the heart and radiated to the carotid arteries. The pulse was irregular and slow. Fine crepitant rales were heard in both lung bases. A chest X-ray showed a normal cardiac silhouette with a dilated ascending aorta. Cardiac catheterization was performed, and severe calcific aortic stenosis was proven. The calcifications that involved the aortic valve were felt to be prominent. During the study the ventricular rate slowed significantly and a temporary pacemaker catheter was placed in the right ventricular apex. The ECG rhythm strip was recorded.



Questions:

1. The ECG rhythm strip shows:
- a. A well functioning demand pacemaker.
- b. Cycle dependent complete left bundle branch block.
- c. Frequent supraventricular capture beats.
- d. Intermittent pacemaker failure.
- e. All of the above.

2. Treatment for this patient will probably include:
- a. A permanent demand pacemaker.
- b. Aortic valve replacement.
- c. Both a pacemaker and aortic valve replacement (a & b).
- d. Digitalis.

(Continued on page 443)

Medical Student Section in Action

Council Liaison Report

The ISMS Council on Mental Health and Addiction, under chairmanship of Dr. Jerome Beigler, has studied a number of different issues this year. Several of these are of direct interest to medical students. One such issue concerns the state licensure application form for physicians required by the State of Illinois Department of Registration and Education. In reviewing the personal history section, the Council found a number of questions concerning conviction record, psychiatric treatment, alcohol and drug use, to be of questionable merit. Although specific questions were asked about an applicant's mental health, no questions inquiring about physical health are included on the application.

Last year, two Council members testified before the Medical Examining Committee of the State of Illinois, asking for revisions in the application form. The Department did not respond to their request. They were informed by the Committee that any applicant who answers affirmatively to the objectionable questions is given a personal interview before any definitive action is taken on their licensure application. The Council is presently seeking review of the application form to determine its legality in relation to federal equal opportunity guidelines.

The Committee on Alcoholism and Drug Dependence, chaired by Dr. Edward Senay, is exploring a possible role for a medical student representative in the activities of the Panel for the Impaired Physician. The exact role of a medical student on the panel would need to be clarified before a student could become a member of the panel. A representative from the ISMS Medical Student Section will be invited to the next committee meeting to discuss the issues involved. The Panel is currently exploring the possibility of assisting other professional organizations in establishing similar programs for their membership.

Additional projects with which the Council has been involved include assisting the Illinois Department of Mental Health and Developmental Disabilities (IDMHDD) with their public education program on fetal alcohol syndrome (FAS). One proposed measure is the addition of a tape on FAS to the Chicago Medical Society's telephone recordings file to make information on FAS more accessible to physicians and the general public. A collaborative project between the committee, IDMHDD and the Dangerous Drugs Commission is in progress concerning development of educational materials for correctional officers and jail health personnel describing signs of alcohol and drug abuse, and triage techniques.

The Board of Trustees has extended formal appreciation to the Sangamon County Medical Society, the MSS and those medical students who worked at the 1981 ISMS Illinois State Fair Booth on alcoholism and hypertension for their help in making the booth a success. At the most recent Council meeting a revision of the ISMS policy manual statement entitled "Active Medical Psychiatric Treatment of Mental Disorders" was completed and approved by the Council. The statement defines what psychiatric treatment encompasses, who is qualified to give such treatment, when such treatment is appropriate and how additional persons may participate in the administration of that treatment.

Reviewing pieces of legislation proposed in Springfield dealing with mental health and substance abuse issues is another important function of the Council. Legislative bills dealing with such issues as: 1) the plea of not guilty by reason of insanity (2) the confidentiality of the doctor-patient relationship and protection against intrusion by law enforcement agencies into that confidentiality (3) child abuse (4) who may become involved with medical decisions concerning wards of the state and (5) disclosure of patient treatment records in court have been considered by the Council during the past year.

Frank J. Pieri
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A Review for the Primary Care Physician

Infectious Mononucleosis

By Daniel G. Cunningham, M.D., Mark S. Puczynski, M.D. and Carlos Maggi, M.D./Maywood

Infectious mononucleosis (IM) is a clinical syndrome representing the human host response to an infection by Epstein-Barr (EB) virus. Identical clinical syndromes have been associated with other agents, notably cytomegalovirus (CMV), rubella and possibly toxoplasmosis. The clinician should consider infectious mononucleosis in the patient who presents with tonsillitis, lymphadenopathy and splenomegaly, especially if accompanied by symptoms of fever, malaise or fatigue. When young children acquire EB virus infection, as occurs often, the clinical response is nonspecific and does not resemble the syndrome of IM as it presents in older children, adolescents and adults.[1,2] Epidemiological studies have shown that in many communities the majority of children have acquired EB antibodies by age two years, especially under circumstances of overcrowding and low socioeconomic status. The popular opinion that IM is a disease of college students is explained by these facts rather than by any concepts regarding its modes of transmission. When the history and physical examination are suggestive of IM the diagnosis can be confirmed readily in the vast majority of cases by demonstrating the presence of circulating antibodies to EB virus and the hematologic response of lymphocytosis, many of the lymphocytes (10%-80%) being "atypical." In clinical practice, the use of simple serologic tests such as the Monospot or heterophil antibody tests are adequate in almost all instances.

Errors in the interpretation of serologic tests

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can occur. Usually seroconversion occurs early in the clinical course of IM but there are exceptions to this rule. If a spot test or heterophil antibody test is negative in a patient with recent onset of symptoms, it should be repeated in one or two weeks. If the repeat test is negative, consideration should be given to more sophisticated serologic testing for IM or to the contemplation of alternate etiologic possibilities, such as CMV, rubella or toxoplasmosis.[3]

False positive serologic tests for IM should be interpreted in light of the fact that in many cases of IM, serological tests may remain positive for weeks or months after the clinical syndrome has subsided. An unexpected positive test may represent a missed infection. More importantly, the persistence of positive serologic tests for IM is not related to persistence of symptoms or activity of infection and serologic tests are quite useless as a guide to patient management. In this context the reference is to routine serological tests only such as Monospot and heterophil agglutinin determinations.

Clinical Variations

The lymphoproliferative manifestations of tonsillar hypertrophy, lymphadenopathy and splenomegaly together with generalized symptoms of fever, malaise and fatigue are the typical presentation of IM. Any or all of these may be absent—many patients are asymptomatic. Other clinical manifestations are not uncommon. Fleeting macular, scarlatiniform or urticarial rashes are noted in some patients but are of no diagnostic value and do not merit the importance given to them in the past.[4,5] A striking exception to this statement is encountered if ampicillin is prescribed in error or for a simultaneous bacterial infection. It is then almost inevitable that a florid macular rash will appear, but not within four or five days of the initiation of therapy.[6]

Case No. I

An adolescent girl developed fever, malaise, fatigue and sore throat. Her physician noted that she had tonsillitis, splenomegaly and lymphadenopathy. Monospot test was positive. Ampicillin 250mg qid was prescribed. Five days later she developed an extensive macular rash on the face, neck and chest. The rash was unsightly and distressing to the patient and caused a great deal of diagnostic confusion until its association with ampicillin therapy was realized.

Central nervous system involvement of a serious nature in IM is, fortunately, unusual. There is no predictable pattern of involvement and many different clinical patterns have been described. These include cerebral cortical and cerebellar encephalopathy, seizures, "Alice in Wonderland" syndrome, myelitis, psychiatric symptoms, the Guillain-Barre syndrome and cranial nerve dysfunction.[7-10] Patients with symptoms of CNS involvement should be hospitalized since most fatalities in IM result from neurological complications. Fortunately, in most cases recovery is complete and usually without prolonged illness.

Case No. II

An adolescent girl presented with tonsillar hypertrophy, adenopathy and splenomegaly. Monospot was positive and blood smear showed lymphocytosis with most lymphocytes "atypical." In a few days she developed subtle symptoms of cerebal dysfunction including intermittent disorientation, inability to recognize familiar people and objects as well as infamiliarity with her surroundings. She was admitted to the hospital. Spinal fluid was abnormal with increased lymphocytes and protein. EEG was also abnormal. The symptoms cleared after several days of observation and recovery was complete.

Infectious Mononucleosis is a lymphoproliferative disease and occasionally the enlargement of lymph glands, tonsils and spleen are such as to constitute major medical problems. Splenic enlargement is associated with a predisposition to rupture. Spontaneous rupture in cases of massive enlargement has been reported but more realistically the danger is from traumatic rupture.[11,12] The age group of IM is also the age group of competitive and contact sports. Patients with IM must be discouraged from participation in activities such as football, cycling and diving until the predisposition to splenic rupture no longer exists. There are no clinical or laboratory criteria to guide the physician in advising patients as to when this predisposition to splenic rupture ends, since it postdates recovery from all clinical and hematological manifestations of the disease. Competitive and contact athletic activity should be prohibited for several months irrespective of any proof of recovery known to us at the present time.[12]

Lymphadenopathy is not associated with suppuration unless secondarily infected. However, discomfort from tender and painful glands can, on occasion, be so severe as to justify steroid therapy. Tonsillar enlargement, often associated with a nasty diphtheria-like membrane, can be so severe as to cause dysphagia and even respiratory embarrassment.[13,14] Careful examination of the tonsils is mandatory in order to rule out associated suppurative complications especially peritonsillar

TABLE I
COMPLICATIONS OF IM NOT DISCUSSED IN DETAIL

1. Peritonsillar Abscess	Usually streptococcal Consider routine throat culture
2. Hematologic Problems	
a. Mild thrombocytopenia	Frequently seen
b. Severe thrombocytopenia	Rare
c. Neutropenia	Rare
d. Agranulocytosis	Very rare
e. Aplastic anemia	Isolated reports
f. Hemolytic anemia	Occasionally
3. Cardiac Involvement	
a. Pericarditis	Very rare
b. Myocarditis	Very rare but life threatening
4. Renal involvement	
a. Usually interstitial nephritis	Many reports
b. Renal failure	Very rare
5. GI complications	
a. Peptic ulcer	
b. Malabsorption	Clinical curiosities
6. Lung and pleura	
a. Pneumonitis	
b. Pleural effusion	Reported, rare
7. Pancreas	
Mild pancreatitis	Reported

abscess. It is always a good idea to do a throat culture. A condition which resembles IM quite closely, clinically, is bilateral tonsillar diphtheria with local adenitis. Fortunately, this is a rare disease, almost unknown in immunized children and associated with brisk polymorphonuclear leucocytosis, a helpful factor in differential diagnosis. Other lesions of differential confusion exist such as Vincent's angina, TB, leukemia and lymphoma.

Case III

A teenager developed sore throat, fever and difficulty in swallowing. Over a period of three days the dysphagia worsened and when examined there was evidence of mild dehydration. The tonsils were large and covered with exudate. There was marked local and mild generalized lymphadenopathy. Spleen was easily palpable. Monospot was positive and the blood smear showed lymphocystosis with many atypical forms. Hospital admission was necessary for rehydration. Over the next few days the dysphagia improved without treatment but the patient developed clinical jaundice. Bilirubin was 6mgm%, mostly unconjugated, and liver enzymes were slightly elevated. The patient required one week of hospitalization and full clinical recovery occurred gradually over a period of several weeks.

Hepatic involvement such as occurred in Case III is encountered in many cases of IM if the clinician actually seeks it out. Most frequently this complication is evident only as mild alterations of hepatic function detected by laboratory screening. Jaundice may occur although liver enzymes are seldom strikingly elevated. Patients are frequently alarmed when informed of complications such as "hepatitis" or "liver involvement" and it is important to reassure them that the prognosis is excellent. Chronic liver disease is not known to occur as a consequence of EB virus infection. In the vast majority of cases it is not necessary to repeat liver function tests even in the face of moderate hepatic involvement. Care must be exercised to distinguish the jaundice of hepatic disease from that of hemolytic anemia which is also a widely reported complication of IM. Other hematologic complications include thrombocytopenia, neutropenia and aplastic anemia.[15] Other complications of IM are included in Table I.

Advice and Management

Patients with IM can be assured that the disease carries an excellent prognosis in spite of the many complications reported in the medical literature.[16] In the absence of neurologic involvement, death is very rare. All patients should be advised of the dangers of splenic rupture since the vast majority of IM patients are in that age group most likely to sustain abdominal trauma.

Fatigue can be a very distressing and prolonged symptom to IM patients and may be actually disabling for several weeks or even months. Skin lesions induced by ampicillin are, of course, preventable. Care must be exercised in prescribing ampicillin if IM is a diagnostic consideration. Penicillin G and phenoxymethyl penicillin are free of this problem.

The use of prednisone or similar steroid hormones should be considered when inflamation of the tonsils causes dysphagia or threatens to obstruct respiration. Many physicians feel that steroid therapy is justified for the relief of discomfort from enlarged inflamed tonsils and lymph glands.

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Treatment Planning With CAT Scanning For Prostatic Carcinoma

By Myung-Sook Lee, M.D., Parvathy Kurup, M.D., Anthony Chung-Bin, M.SC., Thomas Zusag, M.S. and Frank R. Hendrickson, M.D./Chicago

Localized carcinoma of the prostate can be cured by external radiotherapy with local control rates of 82 to 90%.[1-4] The success of localized therapy depends both on treating the full extent of the malignant disease and excluding nearby normal tissues. Impact of computerized tomography on planning of radiation therapy to the prostate is considered.

Twenty-one consecutive patients with potentially curable carcinoma of the prostate were included in this prospective study. Appropriate diagnostic tests, excluding CT, were performed in order to define the patient's disease. All patients were planned with contrast cystography, performed on an AECL simulator. Either lead wire or gastrografin was used to locate the rectum, since barium would have interfered with subsequent CT imaging. Patients with stages A and B well differentiated adenocarcinoma were scheduled for treatment to the prostate only, while others were to receive therapy to the whole pelvis, with a boost to the prostate.

The volume of the prostate was found at simulation as follows: The superior border was determined by the identation of the bladder wall on the cystogram and the inferior border was determined by digital examination and location of rectal markers. The posterior border was given by the anterior rectal wall as found on film and digital examination. The anterior border was defined by the indentation of the bladder wall on the cystogram. When no identation was seen, the anterior field edge bisected the symphysis pubis at least 1.5cm anterior to the posterior-inferior pole of the symphysis on lateral projection (usually at the confluence of shadows of the symphysis and pubic rami). The lateral borders were determined again by identation of the bladder on cystogram, correlated with digital examination. Our treatment volume was then planned to include one centimeter margins on all sides of the prostate.

CT scans were performed using the EMI 5005 scanner, with a custom-made flat couch. This table insert contained longitudinal markers of Delrin rods spaced on 5cm centers, with an additional diagonal rod traversing 5cm laterally for every 10cm longitudinally. The proposed treatment fields were outlined on the anterior and lateral surfaces of the patient with opaque catheters, and a variety of external markers were placed under the patient to determine the precise spacing of the CT scans. These devices were used to overcome distortion of the anatomy and surface contour, non-linear images, uncertain scan magnification and error in setting scan location and spacing. To provide contrast enhancement, 50cc of 10% Renographin were inserted into the bladder and two glasses of Gastrographin given by mouth.

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Transverse cuts of the pelvis were made, starting 1cm below the lower edge of the treatment volume, continuing at 1cm intervals through a point 1cm above the upper border of the treatment volume, and then at 1.5cm intervals up to the level of L2.

The treatment plan was reexamined in light of the CT information, and changed if necessary. Impact of CT findings on the treatment plan was then evaluated by comparing pre- and post-CT plans.

Results

Of 21 patients studied, five were in stage A, eight in stage B, and eight in stage C. (See Table 1.) None of the five patients with clinical stage A disease needed field adjustment, but two (25%) of the eight patients in stage B and six (75%) of the eight patients in stage C required changes.

TABLE 1
Distribution of Stage

Stage	# of Patients	%
A_2	5/21	24
B	8/21	38
C	8/21	38

One of the eight patients in stage C was found on CT to have enlarged pelvic and para-aortic lymph nodes; percutaneous needle biopsy showed metastatic, moderately well differentiated adenocarcinoma. Hormone therapy was given (Table 2).

TABLE 2

Stage	% of Field Adjustment		% of Changing Modality	
A_2	0%	0/5	0%	0/5
B	25%	2/8	0%	0/8
C	75%	6/8	12.5%	1/8

We have analyzed data according to the grade of tumor and stage of disease. There were nine patients with well differentiated adenocarcinoma: one in stage A, six in stage B, and two in stage C. Of these, nine patients, one in stage B and one in stage C, needed field adjustment. Of eight patients with moderately well differentiated adenocarcinoma, three were in stage A, two in B, and three in stage C. Of these patients, one in stage B and two in stage C required field adjustment; the remaining stage C patient required a change in treatment modality.

There were four patients with poorly differentiated adenocarcinoma, one in stage A and three stage C. All three stage C patients needed field adjustments (Table 3).

TABLE 3
Frequency of Field Adjustment in Each Grade of Tumor

Grade of Tumor	% of Adjustment STAGE A		B		C	
Well Diff.	0%	0/1	16.7%	1/6	50%	1/2
Moderately Well Differentiated	0%	0/3	50%	1/2	67%	2/3
Poorly Diff.	0%	0/1	0%	0/0	100%	3/3

Of the eight patients whose treatment fields were adjusted, seven needed enlargement of their fields, three of those on more than one border; only one patient required shifting without field enlargement. No adjustment was more than 1cm in any one direction.

TABLE 4
Frequency of Field Border Adjustment

Type of Border	# of Adjustment	% of Adjustment
Anterior	4/11	36
Posterior	5/11	46
Lateral	1/11	9
Upper	1/11	9
Lower	0/11	0

The frequency of adjustment of each border was: anterior 36%; posterior 46%; superior 9%, and lateral borders 9%. No patient needed a change in the inferior border of the treatment volume.

Discussion

Several recent studies have analyzed the role of CT in treatment planning. Lee, *et al.*,[5] reported experience with CT and ultrasonic imaging in the radiation therapy of 44 patients with prostatic carcinoma. They found with CT that three of 22 patients (14%) had tumor extension beyond the initially simulated treatment fields. As a result 1-2cm were added to the planned treatment portals.

Goiten, *et al.*,[6] reported a prospective study of the value of CT in the treatment planning of 77 patients with a broad range of disease sites. Of patients with pelvic disease, 44% (18 of 44) required planning changes. Munzenrider, *et al.*,[7] reported retrospectively on CT in radiation therapy of 75 patients with various disease sites. They concluded that CT data had been essential to planning therapy for seven of 17 patients (41%) with pelvic disease. However, the effects of the prior knowledge of the CT data on the adequacy of tumor coverage and volume of normal tissue irradiated were less pronounced in the pelvis than

TABLE 5 Analysis of Inadequate Tumor Coverage		
	# of Patients	%
Main Field	1/7	14.3%
Boost Field	7/14	50%
*All of these are marginal miss		

other regions studied. This was because the entire pelvis had been irradiated initially in most cases,[6,7] which tended to minimize the dose reductions caused by marginal geographic misses.

Our own data show only one (14.3%) marginal miss in the main field, but seven (50%) in the boost field (Table 5). It will take many years and a large number of patients to measure the impact of CT scanning on the outcome of radiotherapy of prostatic carcinoma. Evaluation is more difficult when a part of the tumor receives some, but not all, of the dose intended. This difficulty is compounded by the fact that, even when conventional methods of treatment planning are used, we have been able to achieve a local control rate of 83-90%. However, it is expected that integration of CT data into treatment planning will result in improved therapeutic outcome due to increases in both tumor coverage and sparing of normal tissues. ◀

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The Achilles Heel of Muscular Dystrophy

Triceps Surae Tether

By Irwin M. Siegel, M.D./Chicago

In Greek legend, Achilles, the son of Peleus and the Nereid Thetis, is the hero of Homer's Iliad and became the prototype of the Greeks' conception of manly valour and beauty. He was the most illustrious Greek warrior in the Trojan war and slew the Trojan hero, Hector. Achilles had been dipped in the river Styx by his mother. This rendered him invulnerable, except in the heel by which she held him and where he was fatally wounded by an arrow from the bow of Paris, Hector's younger brother.[1]

Of all the deformities with which the child with muscular dystrophy must contend, equinus secondary to gastrocnemius contracture is by far the most disabling. The gastroc-soleus muscle combine is responsible for propulsion, and its tendon is the strongest in the body (its strength is four times as great as the maximal isometric tension its motor muscles can develop; it supports a force almost three times body weight through the toe-heel lever arm during walking take-off).[2] As hip extensor and quadriceps weakness progress, the dystrophic child finds it increasingly difficult to maintain the line of gravity posterior to his hips and anterior to his knees. To accomplish this delicate balance, he widens his base of support and rises on his toes. True calf hypertrophy, secondary to overwork of the gastrocnemius as it assists knee stabilization in extension, ensues (Figure 1), followed by fatty and areolar replacement of muscle tissue (pseudohypertrophy), heel cord contracture and fixed equinus.[3] Because the axis of the subtalar joint is in such a plane that the heel automatically inverts during plantar flexion of the foot, and because the heel cord rotates medially to insert more along the inner border of the os calcis, some degree of foot inversion occurs when standing on the toes.[4] With plantar flexion of the ankle the narrow part of the trochlear surface of the talus occupies the tibiofibular mortice rendering the foot vulnerable to forces which shape a rotatory deformity.[5] Additionally, in fixed equinus, tension in the still active posterior tibial, as well as contracture of the flexor hallucis longus and long toe flexors, contribute to maintenance of the deformity.

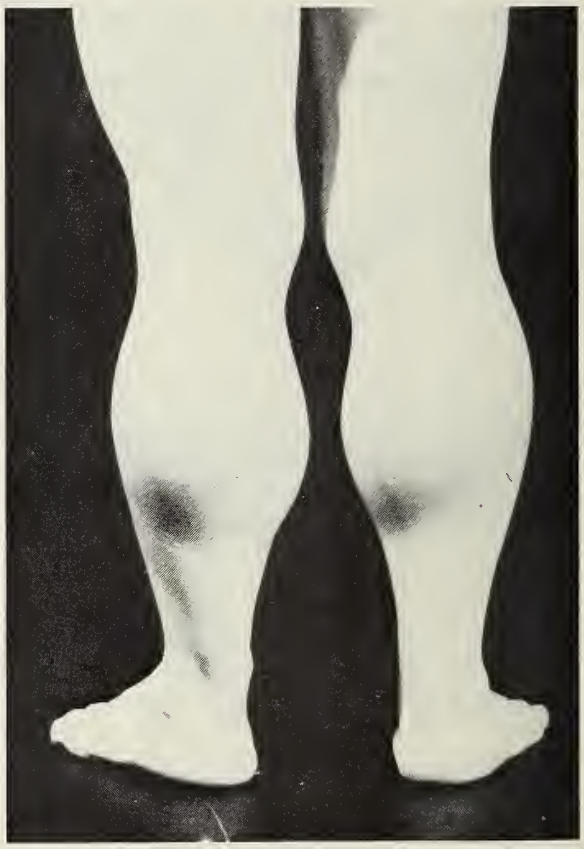


Figure 1
Work hypertrophy of gastrocnemius

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Clinical Correlation

Early on, even before the dystrophic child becomes an obvious toe walker, heel cord tightness can be noted. Anything more than minimal contracture will prevent ankle dorsiflexion during the stance phase of gait. In order to advance beyond the supporting foot, the patient can either

externally rotate at the ankle, shortening the lever arm he has to traverse (this produces a "waddling" gait) or stress his foot in the midtarsal area, flattening his long arch and rolling over the foot lever during stance (this produces a flat foot).[6] Both techniques have been noted clinically, alone or in combination.

With advancing equinus, application of the heel to the ground is achieved at the expense of genu recurvatum, but as quadriceps weakens in the face of usually stronger hamstrings (particularly semimembranosus), back knee is not possible, and the patient *must* walk in equinus (at which point the long arch is reconstructed). Hip extensors weaken with increase in hip flexion contracture; lordosis is exaggerated as strong lumbar muscles contract without adequate antagonist counteraction from weakened abdominal musculature; tensor fascia contracts as the hips are abducted to gain a more secure base of support; equinus increases; with continued alteration of postural dynamics balance becomes untenable and finally the child can no longer stand or walk (Figure 2).



Figure 2
Postural imbalance in advanced Duchenne muscular dystrophy

Treatment

The first essential for treatment is prompt diagnosis. Children with evolving heel cord contracture should wear flat or negatively heeled shoes and be encouraged in active exercises to lengthen the tendon. Passive stretch is effective in staying (but not preventing) contracture if initiated early and performed regularly. Forceful stretching is ineffective, as it excites the stretch reflex through the gamma fibre system, eliciting an augmented contraction which tends to resist the extending force. Passive exercise should be carefully performed, with the knee extended, the heel and foot inverted to prevent dorsiflexion at the transtarsal joints, and with the stretching force applied through the hind, not the forefoot. Children receiving oral steroids for the treatment of inflammatory myopathy as well as several of a small group of Duchenne dystrophics evaluated in a double blind cortisone treatment program seemed to have less severe initial contracture.[7] This may be due to the collagen inhibiting effect of steroid. Direct injection of steroid into the Achilles tendon temporarily increases the effectiveness of passive stretch by decreasing tensile strength.[8] Light plaster or plastic night splints, when tolerated, may help in maintaining the corrected position. Such splintage should always hold the knee in the extended position. When contracture is advanced and equinus fixed, conservative methods are fruitless and operative release of the tendo achillis is indicated.

A variety of surgical procedures are available for heel cord lengthening. These include the Vulpius or Strayer operations for slide-lengthening of the gastrocnemius, the incomplete tenotomies of White or Hauser and the classic Z-plasty tenotomy.[9] Where contracture of the posterior capsule of the ankle joint has occurred secondary to prolonged equinus, Z-plasty may be necessary to gain access to the posterior ankle for release of

its capsule. This can usually be avoided by early surgical intervention, and should, if at all possible, be avoided because the larger operation requires more postoperative restriction, and it is well known that children with muscular dystrophy suffer a profound loss of strength when confined for even a brief period of time.

A less traumatic procedure is the percutaneous tenotomy, which is brief, essentially bloodless, and permits standing in a holding cast the evening of surgery and ambulation the next day. The technique is as follows:

General anesthesia is preferred. Use of a tourniquet is interdict as this can prevent hematoma localization by permitting skin to fall into the space created by separation of the cut ends of the tendon. With the patient supine, a fine tenotome is introduced through a stab wound just medial to the dorsal surface of the insertion of the tendo achillis. The knife enters in a longitudinal direction through the medial wound. The blade is then directed toward the dorsal surface of the tendon, stretching the skin as it proceeds. Thus, when the skin retracts after the procedure, the stab wound comes to lie away from the transected tendon. The blade is then rotated 90 degrees, so that the cutting edge faces the posterior surface of the tendon. It is important to keep the blade on the tendon to avoid cutting either the skin or its underlying supporting layer of tissue; otherwise, a skin slough may ensue.

The foot is forcefully dorsiflexed while pressure is placed on the blade. Only pressure, not a "sawing motion" is used, allowing the tendon to "cut itself" on the blade. One half to two thirds of the cross section of the tendon is transected. The tenotome is removed. On forceful dorsiflexion of the ankle the remainder of the tendon stretches or tears, correcting the equinus. A small dressing is placed on the wound (occasionally, a single 3-O plain catgut suture is necessary) and a long plaster applied. This cast should hold the ankle at 90 degrees and the knee in full extension. The heel and sole of the foot must be well padded; we use wide strips of sheep skin for this purpose. The sole of the cast is pounded soft and the posterior portion fish-mouthed to avoid undue pressue on the stretched, sensitive skin over the patient's heel. Children suffer little pain from this procedure, and nothing more than a mild analgesic is necessary postoperatively. They are able to stand the evening of surgery and ambulate the next day. A walker may be necessary for a short while until the patient recovers his sense of balance, but this aid is usually discarded early as walking confidence is gained. Casts are worn for three weeks, after which the extremities are fitted with light plastic orthoses, incorporating drop ring knee locks but maintaining the ankles at 90 degrees.[10] Occasionally, the quadriceps are graded strong enough (fair or better) to permit the use of a below knee appliance.



Figure 3
Postoperative calcification in healed Achilles Tendon

With this simple technique operating time is minimized and post surgical complications are unusual. Infrequently calcification occurs in the healing tendon but this is of no clinical significance (Figure 3). This procedure has been used successfully in over one hundred cases (bilateral percutaneous Achilles tenotomy) of dystrophic boys 7 to 16 years old, with full correction and no recurrence.

Summary

Heel cord contracture is the major musculoskeletal deformity in muscular dystrophy. Awareness of its inevitability in this disease is necessary for early diagnosis and the institution of appropriate treatment. Minimal contracture is usually amenable to conservative measures, such as passive stretch and night splints. Fixed equinus

requires tendon lengthening which is optimally performed through the percutaneous route.

A vigorous effort must be exerted to prevent Achilles contracture from becoming the Achilles heel of this disease. ◀

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Surgical Grand Rounds

John M. Beal, M.D., Contributing Editor

This month's Grand Rounds were co-edited by Julius Conn, Jr., M.D.

Tertiary Hyperparathyroidism

Surgical Grand Rounds are held weekly on Tuesday, 5:00 P.M., in the Offield Auditorium of the Passavant Pavilion of Northwestern Memorial Hospital. Patient presentations from Northwestern Memorial Hospital and the Veterans Administration Lakeside Hospital form the basis of the discussions. This case report was part of the Surgical Grand Rounds of September 16, 1980.

Dr. Ralph Bashioum: The patient in today's discussion is a white female who was first treated at Northwestern University Medical Center for chronic glomerulonephritis at the age of 18. Progressive hypertension and chronic renal failure had previously terminated a pregnancy. When she was 25 years of age, hemodialysis was initiated. At that time, she complained of bone pain. Due to persistent, severe hypertension, and in preparation for a renal transplant, she underwent bilateral nephrectomy 4½ months after starting hemodialysis. She did well post-operatively, but continued to complain of bone pain. Six weeks after nephrectomy, at age 28, she received a living-related renal transplant from her HLA identical brother. Preoperatively, her serum calcium was 10.8 mg% (normal 8.5-10.5), serum phosphate 7.2 mg% and alkaline phosphatase was 635 units.

One week after transplant, her serum creatinine was 0.66mg%, blood urea nitrogen 15 and creatinine clearance was 100cc/min. At the same time, her calcium had risen to 11.5mg%, serum phosphate decreased to 1.7mg% and alkaline phosphatase was 400 units. During subsequent postoperative course, bone pain resolved.

Follow-Up Data

Eight months following renal transplantation, calcium was noted to be 12.6mg%, serum phosphate had risen to 2.0mg% and alkaline phosphatase had fallen to 134 units. At that time, her parathormone level was 200 units.

Twenty one months after transplantation, serum calcium had fallen to 12%, serum phosphorus was unchanged and alkaline phosphatase was 90 units. Her parathormone at that time was 420 units.

Two and one quarter years after renal transplantation, she was admitted for persistent hyperparathyroidism. At that time, her parathormone level was 500, and alkaline phosphatase level was normal. Serum phosphate was 1.6mg% and serum calcium was 12.5mg%. Upon her admission, she gave a two month history of recurrent bone pain and inappropriate emotional lability. Shortly after admission, she underwent removal of 3-7/8 large parathyroid glands which weighed a total of 4.3 grams. Within 24 hours postoperatively, serum calcium had fallen to 8.1 mg%. Four days following surgery, her serum calcium was 9.4 mg% and she was discharged, taking 2gm. of oral calcium gluconate supplement daily.

One month after surgery, her renal function remains excellent with BUN 12mg%, serum creatine of 0.59mg%, creatinine clearance of 95, serum calcium 10.1mg% and serum phosphate of 2.8mg%. She had relief of all symptoms and does not require supplemental calcium gluconate.

Dr. James S. Wolf: This case has been classically called tertiary hyperparathyroidism. It may be appropriate to review some of the current thinking concerning the relationship of parathormone and the kidney. I hope to demonstrate that there is no such entity as tertiary hyperparathyroidism.

If we review, first of all, the action of para-

thormone in light of the more recent thinking, it is now clear that there are at least two immunologically distinct fragments of parathormone and probably two different biological activities of these different fragments. We are probably looking at the sum total of two activities when we speak of parathormone, rather than a single activity. There is, as has been classically taught, a direct action of parathormone on the bone which increases bone reabsorption. In addition, it is clear that along with Vitamin C or 1,25 dehydrovitamin C, parathormone is also important in the absorption of calcium from the GI tract. The primary action of parathormone, and the primary regulator of calcium metabolism in the body, is renal tubular reabsorption of phosphate. Everything breaks down if the excretion of phosphate does not occur. Hence, in renal disease, the most striking changes in parathormone production occur because the basic and primary function is totally lost: the regulation of tubular reabsorption of phosphate. In addition, parathormone has some activity on the absorption of calcium by the tubules, but this is a very minor function.

It is clear, also, that the adenyl cyclase system is an important regulator of calcium metabolism. This is the mediating system to move calcium in and out of the bone. It works by altering the cellular membrane permeability to ionized calcium. One can use cyclic-AMP as a measurement of activity. Because it is excreted in the kidney, one can measure it only if the patient has normal renal function.

Hypercalcemia, by itself, will increase the level of calcitonin so, if there is any defect of calcitonin, such as in medulary tumors of the thyroid, one may see changes in calcium metabolism that have nothing to do with parathormone. We have classically taught that in some solid tumors there is some parathormone-like activity which produces hypercalcemia. There is now evidence that the mediator here is prostaglandin E which has osteoclastic activity in the absense of any parathormone increase. We must recognize that instead of being *the* regulator, parathormone is only one of the regulators of calcium metabolism.

I think our understanding of Vitamin D metabolism is now more complete. Hydrocalciferol is irradiated in the skin to produce active Vitamin D_3. Active Vitamin D_3 can also be absorbed through the GI tract. This is hydrolyzed in the liver to 25-Vitamin D, and then in the kidney to 1,25 dyhydroxyvitamin D_3. If the kidney is either absent or functioning poorly, the final hydroxylation does not occur. Patients on dialysis for renal failure may not add enough of the 1-hydroxal group to the Vitamin D_3 and as a result the Vitamin D_3 is inactive. The patients with renal failure, in addition to having high phosphate, have defects in calcium absorption because they lack the 1,25 hydroxyvitamin D_3. The action for this pro-hormone is to combine with parathormone to mobilize the calcium from the bone. Its primary activities are to enhance intestinal absorption of calcium and to be active in the renal tubules. It may function in the absence of parathormone to alter the tubular rate of re-absorption of phosphate. The pro-hormone may, in fact, be the prime regulator in the kidney itself.

Overview

Now, what does all this mean clinically? It may be wise to depart from an emphasis on adenomas versus hyperplasia, or primary versus secondary. It seems clear that anything which will increase parathormone or increase parathyroid activity will produce hyperparathyroidism. The causes are multiple. Some of those causes, the causes we don't understand, we call primary. We used to say that it occurred only with an adenoma. It is clear now, that it has occurred in a number of patients in which combinations of adenoma, hyperplastic and normal parathyroid were found. Primary hyperplasia occurs with normal renal function. Probably what we now call primary hyperparathyroidism will, in the future, have several etiologies and we will no longer have primary idiopathic hyperplasia or adenoma.

It is important to remember that parathyroid activity is altered when renal function is altered. Once calcium is deposited in the kidney, tubular function decreases. This decrease adds a degree of secondary hyperparathyroidism to the primary hyperactivity. With adenoma, parathormone levels tend to rise slowly until renal function is altered. When renal function is altered, parathormone will begin to rise very rapidly and to very high levels.

In secondary hyperparathyroidism, the first change occurs when there are not enough nephrons to excrete all the phosphate. Even at maximum excretion, or maximum turnoff of the reabsorption system, one cannot get rid of the excess phosphate. All problems occur from that point. With the decreased handling of phosphate by the loss of total nephrons, there is development of hypocalcemia. With hypocalcemia, there is increased parathormone. In addition, renal failure will produce a decrease in dihydroxylation of Vitamin D, so hypocalcemia is worsened because calcium cannot be absorbed properly. The hypocalcemia will produce an increase in PTH. This will raise the calcium initially, but because of

hyperphosphatemia, the hypercalcemia does not turn off parathormone.

Conclusion

Today we took a patient with secondary hyperparathyroidism from renal disease and added a bulk of nephrons from her brother's kidney to correct the primary cause of calcium metabolism defect.

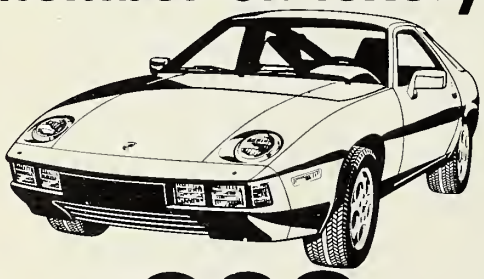
Now, what happens to calcium metabolism? The term tertiary hyperparathyroidism was coined in the early 1960's, when kidney transplant became clinically available. It was used to indicate that secondary hyperparathyroidism had now changed to primary hyperparathyroidism. It has been suggested that this is not true. What one really has is a certain mass of parathyroid tissue stimulated by the secondary hyperparathyroidism. The new kidney provides for excretion of phosphates, and results in an immediate hypercalcemia produced by the increased parathormone levels. If one can sustain the hypercalcemia, this will turn off hyperplastic parathyroid glands.

This is what occurs in most successfully transplanted patients. We observe their laboratory data during the postoperative period and see that they will maintain high alkaline phosphatase, a high calcium, and a very low phosphorus for a period of one to six months. Then these will return to normal. This is the first patient we have seen in a number of years who did not turn off. However, when we did a debulking procedure, or removed 80%-90% of her parathyroid tissue, the hypercalcemia could well suppress the remaining tissue. She now has a normal calcium, normal phosphorus and normal parathormone. By debulking the mass of tissue that she could not overcome, she was able to respond to her secondary hyperparathyroidism just as any other patient following a renal transplant.

We should speak of suppressable secondary hyperparathyroidism or nonsuppressable hyperparathyroidism. We should not use the term tertiary, but look at the hyperparathyroidism either as secondary to renal disease, secondary to another cause, or as primary (idiopathic). If it is suppressable by hypercalcemia following return of renal function, the treatment is to do nothing. If parathyroid function becomes obviously unsuppressable, then the patient should have debulking to remove some of the parathyroid tissue, making it a suppressable secondary, which will eventually return to normal function. ◀

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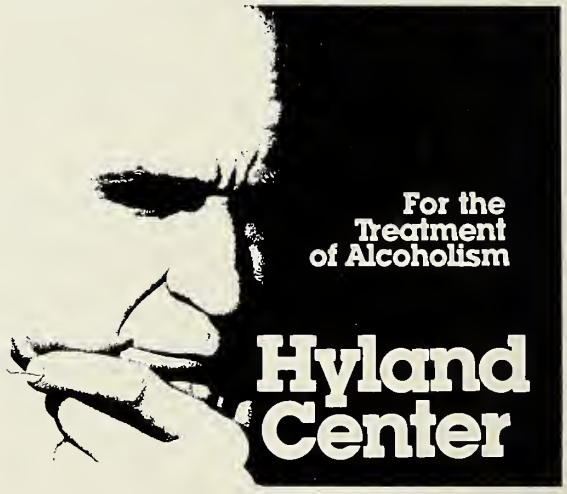
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Part One

DREAMS AND DREAMING

ABD EL AZIZ A. SALAMA, M.D./SPRINGFIELD

Dreams are mental products, in which visual images combine a measure of mystery with seeds of fascination. Dreams are of interest to almost everyone, but whether their study really does lead to a better understanding of personality than can be derived from waking behavior is still unproven. Dreams are evidence of weakening of the intensity of sleep or of sleep disturbance. This view implies that sleep is devoid of mental activity and that the cognition necessary to construct a dream is made possible by partial arousal. Dreams have been found to consist of a changing combination of last day's events and old memory traces.[1]

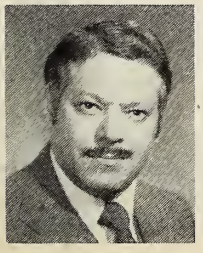
This month's article is the first of a two part series examining that sleep phenomenon. Readers may also wish to refer to the author's earlier review paper, "Sleep Physiology and Disorders," which was published in the January, 1981, issue of IMJ.

Freud,[2] hypothesized that dreaming was a disguised attempt to fulfill an infantile, generally sexual, wish. If the attempt was successful, the sleeping state of the person would be preserved. Kramer,[3] added that Adler assumed that dreaming was a means of generating appropriate affect in order to rehearse for the activities of the subsequent day. Jung postulated that dreaming had a regulatory function that attempted to compensate for exaggerated tendencies in the more conscious aspects of the personality. He felt that, if appropriately attended, dreams could reveal some of the individual truths about the nature of man.

Freud[4] observed that during sleep, our interest is withdrawn from the outside world; and if we dream we believe our dream experiences, no matter how absured or strange they seem when we awaken. These dream experiences were stressed in part by Freud by pointing to the dreams of children under five. Their dreams are simple and understandable once we know what happened to the child the day before. A similar process operates with adults; something happened during the day or few days before, which reawakens a forgotten childhood conflict—a wish we once had which was never gratified. The actual incident may have been a chance phrase or a more important occurrence. But whatever it was, it has something in common with the repressed childhood conflict. At night, this important event acts upon our mental processes as a stimulus, which would disturb our sleep if the wish remained unsatisfied. So, in order that sleep can continue, the wish is gratified via a hallucinatory experience, usually visual. But unlike the simple dream of a child, adult dreams are generally distorted, because our mind acts more freely than it does in waking life, and because the wish to which the dream gives rise is always forbidden. If we recognized what we were doing in our dream, we would awaken or have a nightmare.

Dreams are very much like free association; they express basic unconscious conflicts in a distorted symbolic form. Research suggests that dreams are physiologic necessity and that if we are deprived of them, traumatic effects may result.

Jung added that dreams are of little use in foretelling the future. He may have been right in thinking that they include expressions of an ancient heritage, mingled with repressed features of



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our individual natures.[5] We might even consider Freud, and the hidden passions that our dreams clothe.

Dreams are of special importance in fostering self-observation. When a person reports a dream as if he is telling a story about someone, little will come from it analytically. For dreams to become optimally meaningful, the person and analyst together must attempt to recreate the experience of the dreamer as he dreamed the dream. Few persons will do this spontaneously, and achieving this experience requires the interest of the analyst as well as his awareness of its importance. A dream dryly told without re-creating the dream experience is like a rose under glass. One can see it, but the touch and smell, those qualities that make it alive, are lost.

To understand a dream, French,[6] advises identifying the reality problem the person is struggling to solve, to which the dream is a reaction. The dream can be understood if we stop looking for a rational structure that can be put into words, and think in terms of a structure that is formed by dream behavior. This includes awareness of choices and judgement, though specific actions in the dream may not have a direct and chronologic cause and effect sequence.

Nocturnal dreaming is different from day dreaming. Starker[7] concluded that the two can be reviewed as related, parallel processes, and that positive affect in day dreams was associated with positive affect in nocturnal dreams.

A conscious wish can influence the dream content. Cartwright[8] reported that although the wish influenced the content of the dream, the emotional tone was not always similar between dream and waking states. She concluded that one function of dreaming is to reconcile tension in areas where a discrepancy exists between waking values and behavior.

REM and Dreaming

It is generally accepted that mental activity occurs throughout the entire sleeping period but assumes a slightly more dreamlike character during REM.[9] Subjects awakened from REM as well as NREM sleep report mental activity.[10] Obviously, cognition never ceases while we are alive, whether awake or sleeping, tired or alert. Periods of cognition are distinguished by degree of organization rather than presence or absence of mentation.

When awakened from REM sleep, subjects report a rather dramatic, often bizarre and unreal story of the type we commonly define as a "dream." When awakened from NREM sleep, the subject reports a thought rather than a dream (as if he were thinking); less elaborated and often expressly related to forthcoming activities. The NREM mentation appears to be controlled and reality-adapted, in contrast to the "dreaming" mentation of REM sleep. In other words, if we accept the products of cognition as a behavioral measurement of cerebral arousal, we have to conclude that NREM sleep is lighter, and more alert sleep.

Dream Recall

To Freud, a dream was a personal conflict symbolized, condensed, and displaced through "dream work." This conversion is necessary in allowing the dream to enter into awareness and to be recalled. Associative work will be required to reestablish connections that were disconnected by the dream work. Subjective and experimental evidence indicate that marked individual differences exist in the ability to recall dreams upon morning awakening.[11]

There is almost universal agreement that dreams consist primarily of visual images and imagery.[12] Short-term memory might function both for the immediate recall of dreams upon awakening from a REM period and for the subsequent rehearsal of dream content which would allow the dream to enter long-term memory. Any dream content reported in psychotherapy or remembered sometime after awakening would have to be stored in long-term memory.

Giora,[13] pointed out that the typical REM period is followed by a brief period of arousal, usually too brief for the consolidation of the preceeding dream content into long-term memory. However, when sleep is tenuous, arousal from REM periods may be longer, which explains why we are much more likely to recall our dreams when sleep is disturbed.

Cohen,[14] stated that personality variables apparently account for very little of the variance in dream recall. It may well be that the patient who fails to recall dreams in analysis or therapy is not being resistive, but simply does not have as good a memory as the individual who frequently recalls dreams.

Frequently people claim that they do not dream; actually, they simply do not remember their dreams. Persons who wake up while dreaming, have been found to be better able to remember their dreams than are those who continue with their sleep.

To strengthen dream recall, the subject is advised to make up his mind to recall the dream immediately on awaking and, when he does wake up, to keep his eyes shut and concentrate on the dream. An increase in motivation would increase

the subject's attention to his dream life, possibly increasing the frequency of dream recall.

Functions of Dreams

The dream functions as an unconscious attempt to formulate and clarify personal conflicts.

It represents an effort to find possible solutions to these conflicts. Unconscious and conscious functions confront each other in dreams. By deepening the awareness of what had been unconscious, dreams facilitate the process of personality integration; they reduce tensions, releasing energy which has been tied up in the conflict.

Dreams also reflect the dreamer's feelings, opinions and attitudes concerning types of persons represented by his dream figures, male, female, old, young, etc. These might in turn dramatize the dreamer's internal conflicts.

Typical Dreams and Difference in Sexes

Typical dreams which probably have a universal meaning include being chased, being naked, taking an examination and being rescued. Themes of typical dreams,[15] in rank order of their frequency are: (1) conflicts within the nuclear family; (2) libidinal wishes; (3) concern due to anxiety or conscience and (4) birth fantasies or regressive needs.

It was found also, that male dreams were more active, friendly or hostile than female ones. In the dreams of both sexes, men were the more frequent characters. Men dreamt about fighting men and loving women, while women were more ambivalent about both sexes in their dreams. Men were concerned with the aggressive use of the penis and with castration anxiety, while women showed a fear of the penis, castration wishes and a rejection of the penis. Dream content also differs according to age in both sexes.

Dreams and Drugs

Effect of benzodiazepines: Flunitrazepam,® when given to patients, induced unpleasantness, more verbal and physical aggression and more sexuality in their dreams, clearly indicating a disinhibitory influence. There was a slight trend to a decrease in unreality and bizarreness. The same was also observed with the use of Nitrozepam.®

Effects of antidepressants: M.A.O.I. are capable of suppressing REM, and presumably, indefinitely sustained and total dream deprivation. Fisher[16] described his own use of phenalzine (Nardil®) with three patients. Two of the patients suffered from narcolepsy, the third from painful nocturnal erections. Nardil® succeeded in totally suppressing REM sleep for as long as eight months. The psychotic depression treated with Nardil® began to improve at the point of total suppression of REM sleep. Most psychotropic drugs suppress REM sleep.

Dreams and Mental Illness

Some data on dreams in the acute phase of depression seem fairly well established. When clearly psychotic, depressed patients report relatively bland and barren dreams, usually involving mainly family members and few strangers.[17] As depression lifts, dreams seem to become more troubled. Similarly, masochism and dependency themes apparently remain persistent even after relative clinical improvement during the hospital stay.[3] Beck and Ward,[18] suggest that masochism remains higher in depressives. Even after the acute depression phase has vanished, the patient still sees the world as a generally hostile place.

In a study by Hartmann and Russ,[19] it was concluded that the presence of D-nightmares (nightmares occurring late during the night, with a great deal of dream content), may constitute a "marker" for vulnerability to schizophrenia.

Diseases of the cerebral hemispheres may alter dreaming. Dreaming may cease after parieto-occipital injury.[20] Recurrent frightening dreams may occur in temporal lobe epilepsy as seizure phenomena. Patient's dreams tend to include body-image alterations and typical themes, such as death, falling or drowning.

Interpretation of Dreams

Every dream owes its contents to both past and present. From the remote past come the infantile experiences and memories, as well as the drives seeking gratification. No dream can exist without the impetus of a wish representing the claim of an instinctual drive, which, although infantile in origin, retains an appetite for gratification throughout life.

Current experiences, affects, hopes, fantasies, conflicts and disappointments, whether conscious or unconscious, make a contribution to the dream. While it is true that dreams owe part of their content to a current mental event, the day's residue is not sufficient to produce them. A dream is formed only when the current event makes contact with an impulse from the past, especially with an infantile wish.

The belief that night dreams deal with the anxieties and intentions of the conscious waking life has been widespread, strong and constant. When dreaming, the dreamer reacts very much as he would if his dream events were actual occurrences in waking life. Though differing in details, definitions of the dream function describe it as a

problem solving process. Psychoanalysts believed that interpretation of dreams was "the Royal Road to a knowledge of the unconscious activities of the mind."

Every interpretation of a dream must be custom-tailored, based upon the best evidence available to evaluate and select the essential from a mass of information and impressions. Interpretation has two meanings: the one the therapist makes for himself and the one he offers the patient.

A dream has three distinct entities: manifest dream, latent dream thoughts and dream work. What the patient recalls and relates as his dream is the manifest dream. Underlying the manifest dream are ideas and feelings, some of which belong to the present, some to the past, some preconscious and some unconscious (the latent dream). Latent thoughts and the method by which they are transformed into the images that are recalled is the dream. The process that is responsible for this alteration is called the "dream work."

In attempting to interpret a dream, the therapist should look for the motivating pressure. This is revealed by what the patient says. In reviewing the dream, the therapist may observe how the patient reacted to the dream, what kind of emotional response he showed and what the patient was most concerned about in the dream text. Next, the therapist may trace the dynamic pressure back to the probable sources and then try to determine to what degree the dream contents were distorted. The therapist may observe the action of the dream. The way the ego constructs the dream is indicated by the position of various people, their roles and attitudes. It is quite remarkable how much information one can get from just a quick scanning of the dream. Thus, the dream always relates to the patient's current problems and the dream is a reaction to them.

Most studies on dreams have been concerned with the manifest content of the dream rather than the latent content, which is puzzling in view of Freud's belief that the manifest dream content is of relatively minor importance. The manifest content was viewed as only the starting point in dream analysis in which free association was used as the method of uncovering underlying thoughts[13].

The Meaning of Universal Symbols in Dreams

Freud,[2] in his general introduction to psychoanalysis, described some of the universal symbols which appear in dreams:

- Kings, queens, presidents and people of status as parental figures.
- brothers and sisters as little animals.
- water represents birth.
- setting out on a journey or taking a train indicate dying.
- a house represents the human body.
- clothes and uniforms may mean nakedness.
- a woman has a number of symbols: wood, paper and objects.
- a clock stands for a man.
- male genitals are represented by the number three.
- the breast, as apples, peaches and fruit.
- female genitals are represented by objects which enclose a space or act as receptacles.
- the penis has many representatives, anything long or erect. The property of the penis is its ability to become erect, therefore balloons or airplanes are also symbols.
- pubic hair of both sexes is represented by woods.
- sexual pleasure as candy.
- intercourse as mounting, riding or dancing.

Jung and Dreams

Jung[21] states that the use of dream interpretation is justified from a scientific standpoint as an aid to psychoanalysis. Like all psychoanalysts, Jung thinks of dream interpretation as an aid to restoring and maintaining mental health. He says that one who accepts the belief that the unconscious plays a leading role in function of neurosis will attribute significance to dreams as the direct expression of the unconscious. Without the unconscious the dream is only a freak of nature and a confusion of memory fragments of the preceding day. Dream analysis uncovers hitherto unsuspected psychic material, and apart from its therapeutic value, gives us scientific insight into what Jung called "Psychic Casuality." The dream gives a true picture of the "Subjective State," or how we really feel about ourselves, which the conscious mind cannot or will not give. In the waking state, the dreamer sees himself as he wants to be or should be. Dreaming, he sees himself as he is. Dreams, then, rank with physiologic facts as a method of diagnosis. He adds that they not only help in understanding the past but also offer suggestions as to desirable future activities. Thus, Jung gives his sanction to psychic dreams and offers various interpretations in verification of this belief. He finds, with other analysts, that dreams at the beginning of an analysis are clear and revealing, but later on the dreamer takes over

many of the analyst's ideas and reactions and ceases to reveal himself clearly. His dreams become confused and unintelligible. Should they remain clear, some critical unconscious emotion or attitude has not yet been reached.

Jung declares that the analyst must be ready to evolve an entirely new theory of interpretation for every dream. This would appear to constitute an impossible demand, much simpler in theory than in practice. According to Jung, Freud's theory that every dream is a fulfillment of repressed wishes has long ago been suspended as true of some dreams but not all. Dreams give expressions to "ineluctable truths, to philosophical pronouncements, experiences, even telepathic visions.[5]

Almost half our lives is spent in the unconscious state and, according to Jung, the dream is the utterance of the unconscious. It is likely that the unconscious mind contains a body of content equal to or even greater than that of consciousness, which is subjected to limitations and exclusion.

Jung's views prove that he knew the truth of his statements. In his earlier writings, he said: "It is advisable in the beginning to make use of dreams for the purpose of reaching the important subconscious material by means of the patient's free association with them."[21] Later he says: "Free association is of no value, we must concentrate on the dream images themselves." Dreams reveal the secrets of the inner life and hidden factors of the personality. No individual can understand himself, nor can he be understood, from the side of consciousness alone. Freud, Jung says, looks on the unconscious and its identity with primitive instincts as "little better than a wild beast."[5]

In the treatment of symbolism in dreams, Jung says that we must take into account the dreamer's convictions, both philosophical and moral. Dream symbols must not be regarded as having a fixed meaning. Freud, declares Jung, operates with fixed sexual symbols, and sexuality is supposed to mean something definite. "Freud's concept of sexuality is thoroughly elastic and so vague that it can be made to include almost anything."

Dr. Salama's examination of dreams and dreaming will be continued in the next issue of IMJ.

References

A complete list of references for "Dreams and Dreaming: Part One," may be obtained by writing the *Illinois Medical Journal*, 55 E. Monroe, Suite 3510, Chicago IL 60603.

EKG

(Continued from page 422)

Answers: 1. A. C. 2. C. D.

The ECG rhythm strip shows a well functioning demand pacemaker at a rate of 60 beats per minute. There were frequent supraventricular capture beats in a pattern of double, then single capture beats, separated by two pacemaker beats (wide-QRS beats). This is compatible with high grade or severe atrioventricular block in the absence of any drugs. In addition our patient had severe calcific aortic valvular stenosis and an elevated left ventricular end diastolic pressure. Patients with severe aortic stenosis can present with complaints of convulsions, lightheadedness, congestive heart failure, and cerebral or coronary artery insufficiency. Our patient had two explanations for his symptoms: severe aortic stenosis and heart block. Conduction system disease has been associated with calcific aortic stenosis. Most of these patients have His-Purkinje system disease (prolonged H-V intervals at His bundle study). This could be the result of pressure on the bundle of His from the calcified valve. Atrioventricular node and sino-atrial node disease are uncommon in aortic stenosis. This patient had his aortic valve replaced and a permanent epicardial demand pacemaker successfully implanted. Digitalis was also given in an attempt to improve his ventricular function further. For reading on the topic of aortic valve disease and conduction system disease, see Dhingra, *et al, Annals Int. Medicine* 87:275-280, 1977. ◀

Doctor's News

PHYSICIANS IN THE NEWS—L. Ann Nunnally, M.D., Chicago, has been appointed to serve on the AMA Committee on Allied Health Education and Accreditation. . . . The AMA Board of Trustees has also appointed former ISMS President **Joseph H. Skom, M.D.,** Chicago, to the National Council on Drugs.

Robert J. Freeark, M.D., Maywood, has been awarded the 1981 Stritch Medal by the Loyola University Stritch School of Medicine. Dr. Freeark is a professor and chairman, department of medicine, at Stritch and surgeon-in-chief at Loyola's Foster G. McGaw Hospital. The Stritch Medal is granted annually to an individual making outstanding contributions to the medical profession.

Eugene J. Rogers, M.D., and Herbert Sohn, M.D., both of Chicago, recently received distinguished alumnus awards from the Chicago Medical School Alumni Association. Dr. Rogers is professor and chairman of rehabilitation medicine, University of Health Sciences/Chicago Medical School, a member of the *IMJ* Editorial Board and chairman of the ISMS Committee on Workmen's Compensation. Dr. Sohn, clinical associate professor of surgery, Abraham Lincoln School of Medicine, chief of the combined residency program, Weiss Hospital and Secretary of the University of Health Sciences/Chicago Medical School board of trustees, is chairman of the ISMS Public Affairs Committee. Doctors Rogers and Sohn are among seven alumni honored for scientific and professional contributions and community service.

MEDICAL-LEGAL CONFERENCES ANNOUNCED—The American Society of Law and Medicine will sponsor several conferences on medical-legal issues in the Spring of 1982. Programs on Health Care Labor Law will be held February 19 in Denver, Colorado; March 15 in Houston, Texas and April 30 in New York, New York. Impaired Health Care Professionals will be the topic for a March 5 program at the Detroit Plaza Hotel, Detroit, Michigan. On March 11, ASLM will co-sponsor a two day conference with the Institute for Interprofessional Study of Health Law, University of Texas. That seminar will be entitled "Human Life Symposium: An Interdisciplinary Approach to the Concept of Person." Finally, "Legal and Ethical Aspects of Health Care for Children," will be the title for a March 31-April 1 meeting at the Los Angeles Biltmore Hotel. Further information about the meetings may be obtained by contacting ASLM at 765 Commonwealth Ave., 16th Floor, Boston MA 02215; (617) 262-4990.

PRODUCT PROBLEM REPORTING—the U.S. Pharmacopeial Convention (USPC) coordinates a physician's reporting system intended to improve product quality and encourage communication between industry and government regarding health hazards. The *Drug Product Problem Reporting Program* and the *Medical Device and Laboratory Product Problem Reporting Program* are funded by the Food and Drug Administration and co-sponsored by state and national organizations in health care areas.

Reported problems would include anything that might be noted when a drug is received, used or dispensed; when adverse reactions are experienced with radiopharmaceuticals or when problems with labels, components, packaging, instructions or other parts of medical devices or laboratory products are noted. The USP stresses that anything which could be considered to be a problem should be reported.

USP computerizes reports for trend analysis, copies reports to the FDA and manufacturer and acknowledges receipt. Reporters may be contacted by the FDA, manufacturer or both for additional information about observed problems. Reports or requests for further information may be obtained by contacting the U.S. Pharmacopeial Convention, 12601 Twinbrook Parkway, Rockville MD 20852; (800-638-6725). Other telephone numbers apply in Alaska, Hawaii and Maryland.

SUMMARY OF MINUTES

1981 Interim Meeting

House of Delegates

The ISMS House of Delegates met at the Springfield Hilton in Springfield, November 7-8, 1981, and took the following actions. The official minutes of the House are on file at the Illinois State Medical Society office.

Due to the complexity of amendments to policy manual statements, only the approved, revised policy statements are reflected in this text. Members wishing to study the nature of approved changes may refer to the November, 1981, reference issue of the Illinois Medical Journal, where the former policy statements are published.

OLD BUSINESS

Substitute 80A-2—Adopted
(BOT Rep. B)—Brain Death
Introduced by Vernon H. Bartley for the Du Page County Medical Society

Deleted the current ISMS Policy Statement entitled "Death, Legal Definition of" and replaced it with the following:

DEATH, LEGAL DEFINITION OF

A determination of death is a medical diagnosis which must be made in accordance with accepted medical standards by a physician licensed to practice medicine in all its branches, which may be made when an individual has sustained either: (1) Irreversible cessation of circulatory and respiratory functions, or (2) Irreversible cessation of all functions of the entire brain, including the brain stem.

The House also directed ISMS to cause legislation to be introduced to the General Assembly incorporating the definition of death language as adopted by this House.

Substitute 16 (A-81)—Adopted as Amended
(BOT Rep. C)—Stopping Expansion of HMOs and IPAs
Introduced by Samuel J. Schimel, M.D.

Directed the Board of Trustees to "develop for component medical societies, upon request, public information materials delineating all aspects of existing modes of medical care."

Substitute 26 (A-81)—Adopted as Amended
(BOT Rep. D)—Physician Support for President Reagan's Stand on Medical Care
Introduced by Thomas Meirink, M.D., for the St. Clair County Medical Society

Directed ISMS to: (1) Send to President Reagan a letter of appreciation for his decision not to promote National Health Insurance and for his wisdom in comprehending the problems that can result

from government interference in the practice of medicine; and (2) Offer its cooperation in assisting President Reagan in preventing enactment of any National Health Insurance Plan. Following adoption of the resolution, the House agreed that the letter should also urge President Reagan to support the principle that "under federal rules and regulations the costs and premiums for health care, whether incurred directly by an individual or conferred as an employee benefit, should be equally deductible."

REFERENCE COMMITTEE ON CONSTITUTION & BYLAWS

23 (I-81)—Not Adopted
Unified Membership With AMA
Introduced by Richard Rudman, M.D., for the Marion County Medical Society

Defeated this resolution which called upon ISMS to amend the Bylaws "to allow membership in AMA optional rather than compulsory for members and potential members of ISMS."

26(I-81)—Adopted
Code of Ethics
Introduced by Lawrence L. Hirsch, M.D.

Directed that the following Code of Ethics be adopted by the Illinois State Medical Society not as laws, but standards of conduct which define the essentials of honorable behavior for the physician:

1. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
2. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.
3. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interest of the patient.
4. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.
5. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.
6. A physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.
7. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

REFERENCE COMMITTEE A

1 (I-81)—Adopted
Revision in Policy on Legislation
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement to read:

LEGISLATION

All matters presented to the House of Delegates or Board of Trustees pertaining to state or federal legislation shall be reviewed by the Governmental Affairs Council which shall evaluate its potential impact on the Society's current legislative efforts. The Council shall submit its report to the Board of Trustees, which shall advise and recommend action to the House through the Chairman of the Board.

Matters pertaining to federal legislation shall be checked against recommendations or policies of the American Medical Association by the Council on Governmental Affairs of the Illinois State Medical Society prior to making a recommendation to the Board of Trustees.

Before any legislation is developed for presentation to the Illinois General Assembly, the proposed law shall be considered by the Council on Governmental Affairs which shall work in close cooperation with any other Society committee involved. The instigating committee should determine the content of the law and the Governmental Affairs Council primarily should consider relationship of the proposed legislation to the total legislative program.

Any council or committee recommending

legislation to the attention of the Governmental Affairs Council must provide expert witnesses when called upon to testify before Senate and House committees in support of, or in opposition to, the legislation recommended by the council or committee.

2 (I-81)—Adopted
Deletion of Policy on Reference Committee Appointments
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Deleted "Reference Committee Appointments" statement from Policy Manual because "it is unnecessary for the House of Delegates to provide the Speaker and Vice Speaker with guidance for appointment of reference committee personnel as continuity of experience is only one of several criteria considered by the Speakers in making such appointments."

3 (I-81)—Adopted
Amendment of Policy Manual Statement on "Physicians"
Introduced by Morris T. Friedell, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "Physicians" to read:
PHYSICIANS
The term "Physician" may only be applied to one who has equivalent qualifications of a "physician licensed to practice medicine in all its branches."

4 (I-81)—Adopted
Distinguishing Between Health Planning and Health Regulatory Functions
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed ISMS to "urge appropriate state and federal legislators and health planning officials to distinguish and separate health planning functions from health regulatory functions in accordance with the definition of health planning in the AMA Statement on Voluntary Health Planning."

14 (I-81)—Adopted
Health Planning by State
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Directed the Board of Trustees to: (1) Investigate the potential for state legislation on health planning in the event of nonrenewal of the federal health planning legislation; (2) Make recommendations about what would constitute acceptable and unacceptable elements of a State health planning program; and (3) Report back to the House of Delegates at its next meeting.

5(I-81)—Adopted
Amendment to Policy on ISMS Candidates for AMA Positions
Introduced by Alfred J. Kiessel, M.D., for the Board of Trustees

Amended the ISMS Policy Manual Statement on "ISMS Candidates for AMA Positions" to read:
ISMS CANDIDATES FOR AMA POSITIONS
Selection and/or endorsement of ISMS candidates for positions on AMA Board, councils or major committees should be submitted to the American Medical Association by the ISMS Delegation, through its chairman, after consultation with the ISMS Board of Trustees or its Executive Committee, except when emergency action is necessary because of unexpected vacancies.
Nominations for appointments to subcommittees, ad hoc committees, other minor committees of AMA or as AMA representatives to certain other outside agencies may be made directly by the Chairman of the ISMS Board of Trustees, after consultation with the Chairman of the ISMS Delegation, without specific approval of the full Board of Trustees or AMA Delegation. Such action shall be reported to the Board of Trustees and the AMA Delegation.
Upon receiving notice that an Illinois physician has been nominated for AMA position by an organization other than ISMS, the Chairman of the ISMS Board of Trustees, unless directed to do otherwise by the Board of Trustees, pursuant to the recommendation of the Chairman of the AMA Delegation, shall inform AMA only whether or not the nominee is a member in good standing of ISMS.

Substitute 8 (I-81)—Adopted in lieu of 8 (I-81) & 28 (I-81)
Coverage of Surgical Procedures by Blue Cross/Blue Shield
Introduced by Frank B. Norbury, M.D., for the Morgan-Scott County Medical Society
Perils and Potentials of Ambulatory Surgery
Introduced by Charles DeKovessey, M.D.

Directed ISMS representatives to "meet with officials of Blue Cross/Blue Shield and

the State of Illinois to attempt to resolve the controversy surrounding ambulatory surgery under the State of Illinois Employee Group Insurance Program. Similar discussions should continue as necessary with the Illinois Department of Public Aid."

9 (I-81)—Adopted as Amended
Revision of Multi-Disciplinary Health Care
Introduced by Ronald Welch, M.D., for the St. Clair County Medical Society

Directed ISMS to: "encourage the Illinois Department of Public Aid to reimburse physicians engaged in multi-discipline care of public aid patients without requiring extensive justification procedures."

10 (I-81)—Adopted as Amended
Support of ISMS in Revision of IDPA Administrative Procedures
Introduced by Lloyd Thompson, M.D., for the St. Clair County Medical Society

Directed ISMS to "seek the support of the legislative and executive branches of the State of Illinois in a cooperative effort to work with ISMS for the development of a fair and reasonable system for the administration of the Illinois Department of Public Aid accounting in the service of health care for the poor."

Substitute 13 (I-81)—Adopted in lieu of 13 (I-81)
Informed Consent
Introduced by Kenneth A. Hurst, M.D., for the Board of Trustees

A summary of this resolution was not published upon advice of legal counsel, who is reviewing it.

Reports

Report A of the Board of Trustees was filed for information.

REFERENCE COMMITTEE B

Substitute 7 (I-81)—Adopted
Stiffer Sentencing of Drunk Drivers
Introduced by Ronald M. Davis for the ISMS/MSS

Directed the Society to "support the implementation of S.B. 457 and encourage the Judiciary to recommend rehabilitative treatment as an additional means of dealing with people convicted of driving while under the influence of alcohol."

11 (I-81)—Adopted as Amended
Noting Medical Society Concern for Abused Children Who are Returned to Their Homes
Introduced by Robert Wanless, M.D., for the St. Clair County Medical Society

Directed ISMS to: (1) Make known to all state agencies dealing with family services and allied medical care for families the Society's concern that necessary investigation of the family environment be conducted promptly, prior to the release of the child for return to the same home where the abuse occurred; and (2) Communicate this concern "to the public, state health agencies and family service agencies which become involved in child abuse cases."

12 (I-81)—Adopted as Amended
Impact of Medicaid Financing Changes on Illinois Residency Programs
Introduced by William E. Golden, M.D., for the ISMS/RPS

Instructed the ISMS Council on Education and Manpower and Board of Trustees to "issue a report at the annual meeting of the ISMS House of Delegates that examines the impact of the Medicaid financing changes on the training experiences of Illinois housestaff and its effect on patient care."

Substitute 18 (I-81)—Adopted as Amended in lieu of 18 (I-81) & 19 (I-81)
Infant Car Seats
Introduced by Ronald M. Davis for the ISMS/MSS
Motor Vehicle Child Safety Restraint Education
Introduced by Dennis J. Garwacki, M.D.

Directed the Society to: (1) Support and encourage public education and legislation promoting child safety restraint use (infant and toddler car seats) and encourage physicians and others to discuss their benefits with all parents; and (2) Encourage physicians "to learn about important safety features which have been proven to be effective."

29 (I-81)—Adopted as Amended
Emergency Medical Centers
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society

Directed that: (1) The American Medical Association be urged to expedite its defi-

nition of a true emergency medical center and establish criteria for its operation, with the express purpose of avoiding any misrepresentation to the public; and (2) The Illinois State Medical Society delegation present a similar resolution to the American Medical Association Interim House of Delegates meeting in December, 1981.

31 (I-81)—Adopted
Adequate Health Insurance Coverage
Introduced by Arthur Traugott, M.D., for the Champaign County Medical Society

Called upon ISMS and its AMA Delegation to: (1) Strongly oppose any medical insurance plans which would result in less than adequate health coverage of the total well-being of individuals in this state and country; and (2) Present a similar resolution to the American Medical Association Interim House of Delegates meeting in December 1981.

32 (I-81)—Not Adopted
Unified Membership Status and Extra Delegates
Introduced by Arthur Traugott, M.D., for the Champaign County Medical Society

Defeated this resolution, which called upon ISMS and its AMA Delegation to: (1) Submit a resolution to the 1981 interim session of the House of Delegates urging the AMA Board of Trustees to recommend for admission as new delegates only from those specialty societies or other physician organizations which accept the current goal that AMA shall speak with one voice for all of medicine; and (2) Request the AMA Board of Trustees to seek amendments to the Bylaws to provide recognition for those states which encourage speaking with a unified voice by allotting an extra delegate to those states committed to unified membership.

36 (I-81)—Adopted as Amended
Reorganization of the College of Medicine
Introduced by Forrest H. Riordan, III, M.D., for the Winnebago County Medical Society

Directed ISMS to inform Dr. Ikenberry, President of the University of Illinois, that "we would desire in considering the reorganization of the College of Medicine (that) President Ikenberry, the Board of Trustees of the University of Illinois, and the Board of Higher Education recognize the importance of the Regional Medical Centers being semi-autonomous from the Chicago campus, with their own deans and department heads, and with academic freedom in organization of their educational structures so long as they conform to the standards of excellence within the University of Illinois."

REFERENCE COMMITTEE C

20 (I-81)—Adopted
Physician Control Over Peer Review
Introduced by Fred Z. White, M.D., for the Board of Trustees

Endorsed the principles that: (1) "ISMS supports physician assessment of the quality of medical care regardless of the future fate of PSROs;" and (2) "Physicians (should) maintain control and direction over peer review, regardless of what mechanisms evolve for peer review, and over public or private funds that are directed to such activities."

21 (I-81)—Adopted as Amended
ISMS' Role in Future of UR Activities
Introduced by Fred Z. White, M.D., for the Board of Trustees

Directed the Board of Trustees to: (1) Undertake a study of the future of utilization review activities, delineating the various alternative approaches available to the medical profession; and (2) Report the recommendations contained in the study to the next meeting of the House of Delegates.

22 (I-81)—Not Adopted
Proposed Position Paper on Utilization Review
Introduced by Fred Z. White, M.D., for the Board of Trustees

Defeated this resolution which called upon ISMS to endorse a proposed Position Paper on Utilization Review as representing the views of the Illinois State Medical Society.

24 (I-81)—Not Adopted
Conflict of Interest Among Leaders of Foundations and Medical Societies
Introduced by Samuel J. Schimel, M.D.

Defeated this resolution which called upon ISMS to: (1) Urge "any member of a foundation for medical care in a leadership capacity who is elected president, vice-president, or secretary of a local medical society (to) resign from his office in the foundation for medical care or PSRO in order not to create a conflict of interest;" and (2) Urge county medical societies to amend their Bylaws accordingly.

30 (I-81)—Adopted as Amended
PSRO
Introduced by Joseph R. O'Donnell, M.D., for the DuPage County Medical Society.

Directed that "any further peer review activities be performed by a local medical society, or its designee, on a local level whenever possible."

33 (I-81)—Not Adopted
Appropriate Role for Outside Peer Review Organizations
Introduced by Morris T. Friedell, M.D.

Defeated this resolution which called upon ISMS to endorse the following statements: (1) "Peer review of individual physician practices (should) be a function and responsibility of hospital medical staffs utilizing methods that conform with the standards and goals established by the Joint Commission on Accreditation of Hospitals, as well as the rules and regulations of the hospital and applicable law;" (2) "Outside peer review organizations shall not monitor individual physician practices but, instead, assess the practice of the hospital as a whole and compare it to other hospital functions in the community or in similar communities (generic review);" and (3) "The Illinois State Medical Society (should) not undertake any peer review function as a superior review body, but leave that responsibility to local medical societies and other designated local organizations."

34 (I-81)—Not Adopted
Appropriate Functions for Hospital UR Committees
Introduced by Morris T. Friedell, M.D.

Defeated this resolution which called upon ISMS to endorse the following statements: (1) "Quality assessment, peer review and cost containment are appropriate functions for a hospital Utilization Review Committee;" and (2) "Hospital Utilization Review Committees should continue to assess the quality, appropriateness, length of stay (including pre-admission testing), pre-operative and post-operative length of stay, selection of patients for ambulatory care services and other services including medical and pharmaceutical services; and monitor the admitting and discharge patterns of individual staff physicians."

35 (I-81)—Not Adopted
Peer Review Organizations
Introduced by Morris T. Friedell, M.D.

Defeated this resolution which urged that: (1) Peer review organizations sponsored by physicians have only physician input into activities of UR Committees; (2) Such review organizations confine their activities to data collection and comparison of data from hospital to hospital within the same areas and that such data be made available only to qualified organizations approved by the local medical society; (3) The Illinois State Medical Society (shall) serve only as a support center for local peer review organizations; and (4) The Illinois Cooperative Health Data Systems be the organization having statewide responsibility for the collection, analysis and publication of data results.

37 (I-81)—Adopted
IDPA and Utilization Review
Introduced by Audley F. Connor, Jr., M.D., for the Board of Trustees

Directed ISMS to "urge IDPA to continue to use existing physician peer review organizations, and . . .vigorously oppose the use by IDPA of any alternative peer review structure."

38 (I-81)—Not Adopted
Definition of Peer
Introduced by Lorris M. Bowers, M.D., for the Peoria County Medical Society

Defeated this resolution which called upon ISMS to endorse the following statement: "For purposes of peer review, a 'peer' shall be a properly and currently licensed individual whose type of practice is appropriate for the medical question under consideration and, whenever possible, whose primary practice is in the community involved."

OTHER ACTIONS

The House of Delegates also approved the following motion from the floor:

It shall be the policy of the House of Delegates that the business of the House and its reference committees not be interrupted by the distribution of extraneous information or information from non-constituent organizations during the conduct of its business.

RESOLUTIONS DEFERRED

The following resolutions were deferred for consideration at the 1982 Annual Meeting:

- Res. 6 (I-81)
 Deterioration of Health in Inner City Areas
 Introduced by Ronald M. Davis for the ISMS/MSS
- Res. 16 (I-81)
 Motorcycle Helmet Use
 Introduced by Ronald M. Davis for the ISMS/MSS
- Res. 17 (I-81)
 Seatbelt Use
 Introduced by Ronald M. Davis for the ISMS/MSS
- Res. 27 (I-81)
 Deadline for Submission of Resolutions
 Introduced by Raymond Hoffman, M.D., for the Winnebago County Medical Society

RESOLUTIONS WITHDRAWN

The following resolutions were withdrawn by their sponsors prior to consideration by the House:

- Res. 15 (I-81)
 Registration for Students and Residents at ISMS Sponsored Workshops & Seminars
 Introduced by Ronald Davis for the ISMS/MSS and William Golden, M.D., for the ISMS/RPS
- Res. 25 (I-81)
 Service Tax on Medical Profession
 Introduced by Samuel J. Schimel, M.D.

LATE RESOLUTION NOT ACCEPTED

- Res. 39 (I-81)
 Hospital Medical Staff Appointments and Privileges
 Introduced by Donald W. Aaronson, M.D. ◀

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Abstracts of Board Actions

(Continued from page 418)

SOCIETY TO HONOR DR. JAMES W. WEST

Dr. James W. West, Evergreen Park—founder and chairman of the ISMS Panel for the Impaired Physician—will be honored by ISMS for his contributions to the Society as well as public service groups. An appropriate award will be presented to Dr. West in 1982. Dr. West plans to relocate in California.

IDPA DRUG MANUAL

The Board approved the following drugs for inclusion in the IDPA Drug Manual: Cortisponsin Otic Sol/ Susp/Opht Ont/Susp., Bactrium IV and Reglan. The Board also recommended that the following drugs be deleted from the IDPA Drug Manual: Phenybutazone/Aluminum Hydroxide, Cordran-N Cream/Ointment, Neggram, Trimethoprim, Methenamine, Troleandomycin, Vancocin Injection, Furoxene and Dexpanthenol.

ELECT ICCME BOARD FOR 1982

The Executive Committee reported that—as the corporate members of ICCME—it elected the following ISMS representatives to the ICCME Board of Directors for 1982: *Drs. Robert A. Behmer,* Rockford; *E. Chester Bone,* Jacksonville; *Dean R. Bordeaux,* Peoria; *Jere Freidheim,* Chicago; *Lawrence L. Hirsch,* Chicago; *Kenneth A. Hurst,* Naperville; *Donald F. Pochyly,* River Forest; *Robert L. Prentice,* Springfield; and *Fred Z. White,* Chillicothe.

The corporate members also elected the following medical school representatives to the ICCME Board of Directors for 1982:

- Ben B. Blivaiss, Ph.D., Chicago Medical School
- Michael Dykes, M.D., Northwestern University Medical School
- Linda K. Gunzburger, Ph.D., Loyola University, Stritch Sch. of Med.
- Marten M. Kernis, Ph.D., University of Illinois College of Medicine
- Chase P. Kimball, M.D., University of Chicago Pritzker Sch. of Med.
- Charles E. Osborne, Ed.D., Southern Illinois University Sch. of Med.
- Harold A. Paul, M.D., M.P.H., Rush Medical School
- Ward E. Perrin, D.O., Chicago College of Osteopathic Medicine

APPOINTMENTS/NOMINATIONS

Drs. James Lewis, Lake Forest, and *Augusta Webster,* Chicago, were named consultants to the ISMS Committee on Maternal Welfare.

Drs. Robert Behmer, Rockford, and *Fred Z. White,* Chillicothe, were nominated for appointment to an Accreditation Council for Continuing Medical Education task force which will develop uniform standards by which states accredit local institutions and organizations and methods for assuring compliance with those standards.

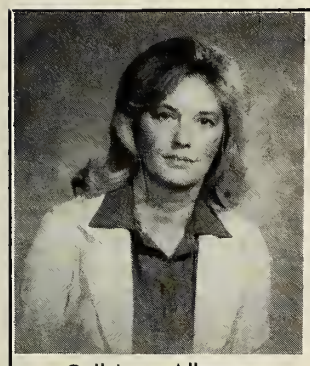
Drs. Peter Heinbecker, Belleville, and *Maynard Shapiro* and *Harry Springer,* both of Chicago, were nominated for appointment to an ACCME task force which will prepare a handbook, interpreting and explaining the revised Essentials as they relate to community hospitals and other intrastate institutions and organizations.

OTHER ACTIONS

In other actions, the Board of Trustees:

- Selected the Palmer House in Chicago as the site for ISMS' 1982 Annual Meeting, Friday through Sunday, April 16-18.
- Agreed to loan the Society's newly-developed HMO-IPA slide presentation to component and affiliated medical societies at no cost, other than handling charges.

- Authorized a mailing to component societies requesting: (A) Assistance in identifying problems of hospital medical staffs; and (B) Recommendations on how hospital medical staff problems can be resolved successfully. The information will be utilized by the Council on Economics in the implementation of Resolution 37 (A-81), which directed the Society to assist medical staffs in negotiating with hospital administrators and boards.
- Authorized PruCare of Illinois—formerly Northcare—to make a presentation to the ISMS staff regarding its health maintenance organization benefits package. PruCare, a federally-qualified HMO, is an operating division of the Prudential Health Care Plan, which is a wholly owned subsidiary of the Prudential Insurance Company of America. Federal regulations provide that employers "shall offer the option of membership in a qualified HMO to each eligible employee . . . who resides within the service area of the qualified HMO" if it requests inclusion in the employer's health benefits plan.
- Declined an invitation to establish liaison with naprapathy and agreed to continue its monitoring activities relating to creation of new categories of licensure in the health professions.
- Ratified an action terminating Peat, Marwick, Mitchell & Co. and retaining Ernst & Whinney as the Society's certified public accountants through Dec. 31, 1982.
- Appointed Gerald J. Sullivan and Associates as the new broker and consultant for the Society's Employee Retirement Plan.
- Directed Corroon & Black, ISMS insurance plans administrator, to change insurance carriers on the Society's professional overhead expense plan from The Provident Life and Accident Insurance Co. to the Hartford Accident and Indemnity Co., effective Jan. 1, 1982.
- Approved revisions in the ISMS sponsored Disability Income Plan effective April 1, 1982. ◀



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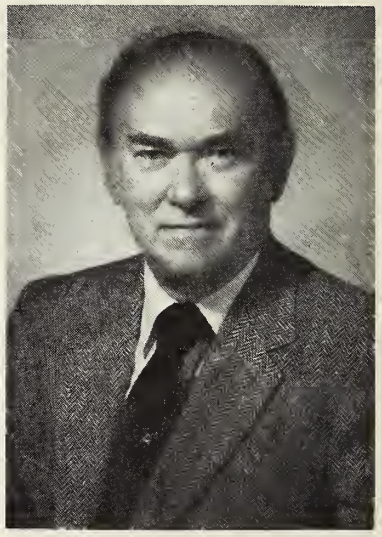
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President's Page

Consider the Alternative



Not long ago, I asked a 94-year-old patient how he was feeling. His response was very insightful: "Considering the alternative, not too bad!"

The positive and negative aspects of any situation must be judged against some comparative data base. When changing or eliminating any structure, one must consider alternatives during the decision-making process.

Consider, for example, the issue of health planning. It seems apparent that HSAs will lose their funding and pass from the national scene. That occurrence probably was inevitable since health planning legislation with its negative regulatory mechanisms (certificate of need, etc.) was designed to fail.

However, health planning will not simply disappear. It will continue at the institutional level within the administration and governing boards of hospitals. It surely will continue at the state level within the Department of Public Health. And a new form of health planning—the coalition—also is emerging. For example, businesses or industries, who are major purchasers of health care, are forming such coalitions because they recognize the need to be part of the planning and decision-making process to control their costs.

While these approaches to health planning may be laudable in their intent, a major defect exists. HSAs and the Comprehensive Health Planning (CHP) agencies they replaced had physician and medical society input. We physicians learned to work with these agencies. And our voices were heard even if we did not win on a particular issue. HSAs also had some democratic characteristics in that physicians could participate as members of technical advisory committees or HSA boards themselves.

It is best not to rejoice at the fact that the days of HSAs are numbered. Instead, we should simply accept that fact while we consider the alternatives. ◀

Fred Z. White, M.D., President

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Illinois State Medical Society
Political Action Committee
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Contributions are not limited to the suggested amount. Neither the Illinois State Medical Society nor the AMA will favor or disadvantage anyone based upon the amounts of or failure to make pac contributions. Contributions are subject to the limitations of FEC regulations, Sections 110.1, 110.2, & 110.5. (Federal Regulations require this notice.) IMPAC reports are filed with the State Board of Elections, and are or will be available for purchase from the State Board of Elections, 1020 South Spring Street, Springfield, Illinois, 62704. Voluntary membership contributions support political action committee membership in IMPAC for candidates for public office in Illinois and candidates for federal office elsewhere through AMPAC.

Physician Recruitment Program

In an effort to reduce the number of towns in Illinois needing physicians, the Physician Recruitment Program and the Doctor's Job Fair, are publishing synopses in the Journal.

Physicians who are seeking a place to practice or who know of any out-of-state physicians seeking an Illinois residence are asked to notify the Program.

Any areas wishing to be listed should contact: Physician Recruitment Program, ISMS, 55 E. Monroe, Suite 3510, Chicago, 60603.

AURORA: Population 85,000-opening for cardiologist in well-established group of 45 physicians. Excellent hospital and clinic space available. Located 50 miles from downtown Chicago on E/W Tollway. CONTACT: L. E. Snyder, M.D., 1870 W. Galena Blvd., Aurora 60506 (312-859-6700). (12)

BENTON: Family Physician wanted to join growing medical staff associated with a modern, 113-bed community hospital in southern Illinois. Guarantee and other benefits. Excellent recreational and university facilities nearby. CONTACT: Ann Acton, Franklin Hospital, Benton, 62812, (618) 439-3161, Ext. 367/368. (4)

CARBONDALE: Family or General Practice. Community Health Center in southern Illinois, 10 miles from SIU-Carbondale. Affiliation with Black Lung Clinic Programs possible. Established practice with multi-disciplinary staff. Position available immediately. Salary, fringe benefits are very competitive; malpractice insurance and vacation also provided. CONTACT: George M. O'Neill, Shawnee Health Service & Development Corporation, 103 S. Washington, #210, Carbondale 62901 (618-457-3351) (4)

CENTRAL ILLINOIS: Two community hospitals within twenty minutes of each other are currently seeking a urologist. Possible partnership with consulting urologist now servicing this area. More patients than one urologist can handle. Area is known for recreational activities. Contact: Search Committee, P.O. Box 430, Pana, 62557. (217-562-2131 x271) (4)

CLIFTON: Service Area, 8,500—Immediate opening for family practitioner in rural setting. First year: guarantee, office space/staffing provided. Seventy miles south of Chicago on interstate highway. Excellent school system. Obstetrics or general internal medicine background helpful. CONTACT: George Rasmussen, Central Community Hospital, Clifton 60927. AC 815-694-2392. (10)

CLINTON, IA: Internist (with/without subspecialty), Surgeon, OB-GYN, and ENT physicians are needed in Clinton. Multi-specialty group serving large part of Western Illinois. Excellent opportunity for quality care, professional interaction with friendly colleagues and financial security. Contact Dr. Daniel J. Baxter, collect: 319-243-4600 days or 319-242-6451 nights. (2)

DU QUOIN: Opportunities for solo or group practice in well known small community. St. Louis 75 miles. S.I.U.-Carbondale 25 miles. Excellent schools, churches, shopping, housing and recreation. JCAH hospital specializing in quality care. Du Quoin and Marshall Browning Hospital would love to tell you more. Call David R. Hosler, Adm., collect at 618-542-2146. (12)

FAIRBURY: Family Practice Physician to join fast growing practice in thriving rural area. Well-equipped, JCAH accredited, 112-bed hospital offers income guarantees and other financial assistance. Send Curriculum Vitae in confidence to Frank Brady, Administrator, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (12)

FAIRBURY: Family practice physician—Excellent opportunity to join General Practice Physician planning retirement in two years. Cross coverage is available in this thriving rural practice. Fairbury Hospital, a 112-bed JCAH accredited hospital, offers income guarantees and other financial assistance. Contact: Kate H. Dickey, Director, Physician Recruitment, Fairbury Hospital, 519 South Fifth Street, Fairbury 61739. (815-692-2346 x215) (4)

FRANKFORT: Multispecialty group seeks young family physician, willing to do OB and also seeking OB-GYN—to join expanding practice, which is located some thirty miles southwest of Chicago. Incentive plan, profit sharing; as well as a new building. Excellent practice opportunities. CONTACT: Howard Osmus, Administrator, Hedges Clinic, Frankfort 60423 (815-469-2123). (1)

FREEPORT: Otolaryngologist, Cardiologist, Gastroenterologist, General Internist, Family Practice, Urologist—to join expanding 20 physician multi-specialty Clinic. This 30 yr. old group practices in a new facility across from a recently expanded general hospital in a community of 30,000. CONTACT: C. Wm. Metcalf, M.D., Medical Director, Freeport Clinic, S.C., 1036 W. Stephenson St., Freeport 61032, 815-235-5111. (12)

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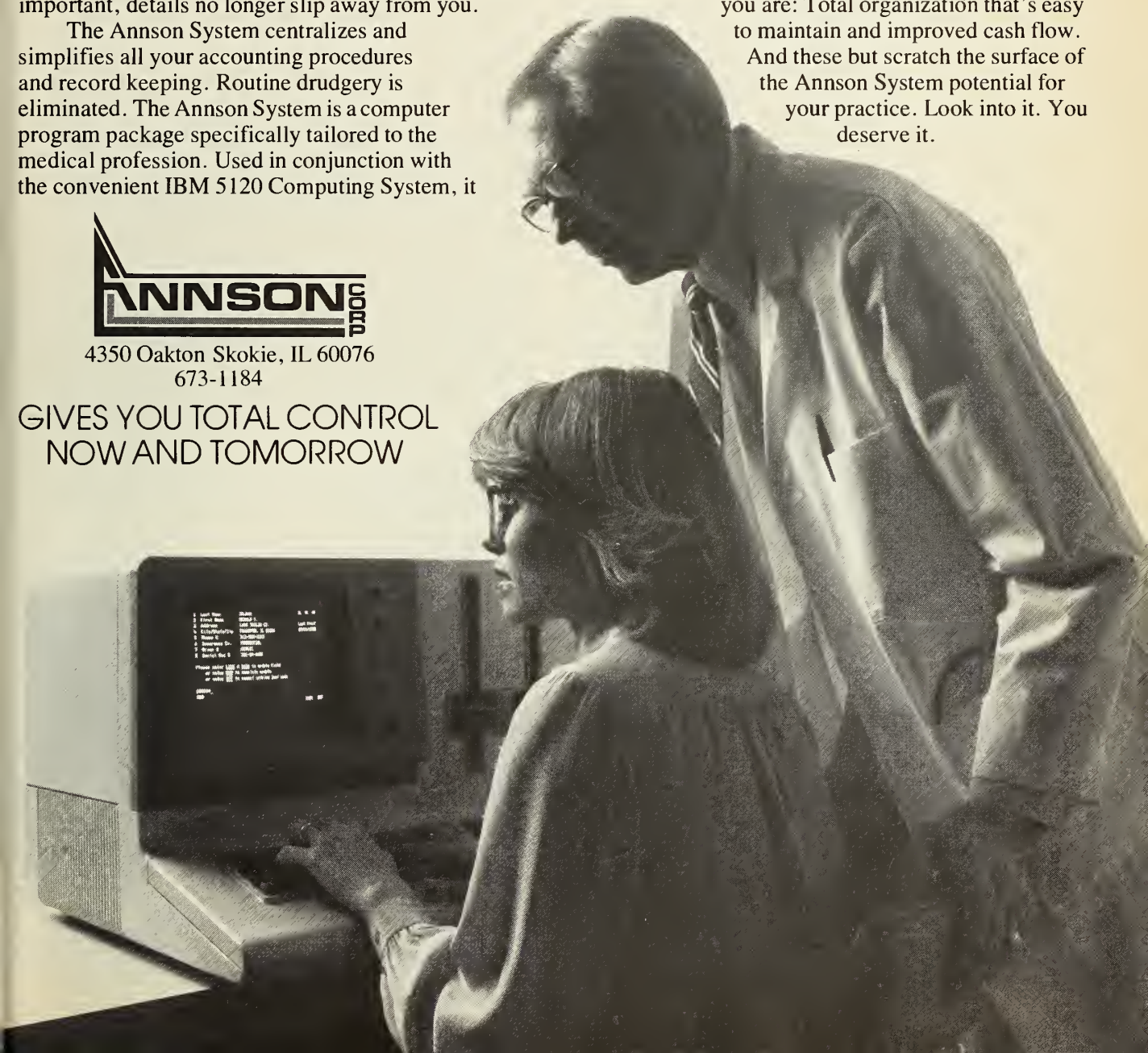
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FAMILY PRACTITIONER—To locate in Nashville, Illinois. Excellent educational system and recreation. Financially sound community. One hour from St. Louis. JCAH 72-bed hospital in Nashville. Contact: T. K. Janssen, Administrator, Washington County Hospital, Nashville, Illinois 62263, 618 327-8236.

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EMERGENCY PHYSICIAN—join 5 full time physicians with peak load double coverage. Average 28 hours weekly but scheduled such that are off 4 of each 6 weeks. Income and bonuses average $100,000 plus $37,000 non-taxable fringe benefits yearly, including $100,000,000 liability- $50,000 life- $2000 monthly disability- $100,000 accidental death- basic and major medical health and accident insurance programs, Pension and Profit Sharing plans, dues, licenses and up to $5000 non-taxed, yearly reimbursements all provided by Corporation. Clean, central Illinois town with new Civic Center, private University, much industry and rich farm land. Apply with C.V. to: Box 1026, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago, Illinois 60603.

EMERGENCY MEDICINE POSITION AVAILABLE—Full-time emergency physician wanted for moderate volume trauma center. Two hour drive from Chicago. Friendly agricultural community of 12,000. Competitive hourly rates and excellent benefits including malpractice insurance. Call Linda Miller, Emergency Consultants, Inc. *collect* at (312) 222-9696.

FAMILY PRACTITIONER—Immediate practice open in satellite clinic area for board eligible or board certified family practitioner to affiliate with 45 man multi-specialty group in a southeastern suburb of Chicago. First year guarantee of $55,000 with immediate opportunity to earn more thru incentive plan. Write to Box No. 1029, c/o Illinois Medical Journal, 55 E. Monroe, Suite 3510, Chicago IL 60603.

WANTED: PHYSICIAN to share office or take over lease, 344 College Ave, Rockford (SouthWest area), seeing 20-30 patients daily. # 815-964-0500. 11-5 PM.

RESIDENT IN ANESTHESIOLOGY wanted for research, diagnosis and patient care in all areas of anesthesiology. Requires M.D. degree and one year residency in anesthesiology. 40 hours per week, $20,000 per year. Contact Donald W. Benson, M.D., Ph.D., Chairman, Dept. of Anesthesiology, University of Chicago, 950 East 59th Street, Chicago, Illinois 60637. Telephone: (312) 947-6128.

EXCELLENT NEUROSURGICAL OPPORTUNITY. 50+ physician multi-specialty group in western suburbs seeks dynamic neurosurgeon for immediate opening. Excellent guarantee plus incentive from first month, competitive benefits and unusual opportunity for independence and development within a strong group practice. Contact: James A. Mini, M.D., President, Glen Ellyn Clinic, S.C., 454 Pennsylvania Avenue, Glen Ellyn, Illinois, 60137 (312-469-7700).

FAMILY PRACTICE/EMERGENCY MEDICINE—Combine the satisfaction of a family practice with the challenge of emergency care. Full time position available in April, 1982, for board eligible/certified FP. Outpatient service only—no OB, surgery, or in-patient responsibilities. Generous compensation with paid malpractice, four weeks vacation and financial incentive. Forward CV or contact H. Stratton, M.D., 2404 E. Washington Road, E. Peoria, Illinois, 61611, (309) 694-6464.

WANTED: Part time physician, internal medicine or general practice for Winnebago County. Choose own hours and days. Call (312) 432-4250.

Medicaid-Medicare-Champus Report

For approximately three months, physicians in Illinois have been billing the Illinois Department of Public Aid under the new claims processing mechanism of the Medicaid Management Information System (MMIS). Although this program is relatively new to physicians' offices, the Illinois State Medical Society has spent more than three years negotiating with IDPA on numerous aspects of the MMIS program and its impact on physicians. The purpose of this article is to explain these ISMS-IDPA negotiations and discussions with other government health care reimbursement agencies on behalf of member physicians.

These issues continue to affect the financial viability of a physician's practice. Articles on the Medicaid, Medicare and CHAMPUS programs will now be a regular feature of the *IMJ*.

The articles will be about potential reimbursement problems that can directly affect a physician's medical practice. The Society is committed through its Committee on Third Party Payment Processes to assisting the membership in resolving these government health care reimbursement disputes. ISMS' Division of Professional Relations has the responsibility of working directly with members on a daily basis to help mediate problems and clarify policies of government health care reimbursement programs. If you or your office staff have inquiries about reimbursement policies under these programs, and are unable to obtain satisfactory assistance from program administrators, contact your ISMS Field Representative in Chicago at 312/782-1654.

EARLY MMIS NEGOTIATIONS — In 1978, ISMS entered into negotiations with IDPA to discuss many objectionable aspects of the MMIS Program. The Society and the Department have worked to modify, eliminate or compromise on many of the more objectionable features of the new IDPA claims processing system. One major concession that resulted from these discussions was IDPA's agreement to adopt the AMA Universal Health Insurance Claim Form in lieu of the original MMIS invoice prepared by the Department. Listed below are additional aspects of MMIS that the ISMS Committee on Third Party Payment Processes has negotiated with the Department since 1978:

MODIFICATIONS TO THE MMIS PROVIDER ENROLLMENT APPLICATION — Subsequent to an ISMS proposal, IDPA agreed to accept the physician's Illinois state license number in lieu of the Social Security or AMA number as the MMIS provider identifier. ISMS successfully negotiated the multiple payee options for physicians whose IDPA income derives from a group, clinic or other corporate practice. IDPA will now allow the opportunity for participating physicians to designate payments under MMIS to more than a single address.

MODIFICATIONS TO THE MMIS/AMA CLAIM FORM — IDPA agreed to re-classify many data fields on the invoice from "Required" to "Optional" or "Conditionally Required" fields. For example, ISMS dissuaded the Department from requiring both a written and a coded diagnosis on the form. IDPA also agreed that physicians need not check "No" in the "Accident," "EPSDT," and "Family Planning" boxes when these conditions were not applicable. At ISMS urging, the Department scuttled its original plan to require that physicians complete inapplicable third party liability fields. Many of these items are minor, but collectively, they would be a substantial burden.

IDPA agreed to publish in their *Handbook For Physicians* a listing of most common ICD-9-CM diagnosis codes for use by physicians when billing under MMIS. Under IDPA's original plan, Illinois physicians would have been required to purchase the three-volume ICD-9-CM series at a cost of approximately $45.00 in order to submit claims to IDPA.

IDPA accepted ISMS proposals for more clearly defined medical record keeping requirements. Moreover, the Department published much of the technical data solicited by ISMS from the Illinois Psychiatric Society regarding special procedures and documentation requirements for psychiatric coding.

IDPA agreed to accept CPT-IV as its procedure code.

MMIS MONITOR ACTIVITY — Since the MMIS program was implemented, the Society has continued to monitor the actions of the Department. For example, ISMS learned that most participating providers were inadequately informed by the Department about the mechanics of the new MMIS billing system and were not prepared to submit claims for processing. Additionally, the necessary materials for submitting claims were not mailed to physicians' offices in sufficient time to submit bills to the Department. The Society staff alerted IDPA administrators to these issues in an effort to resolve the problems for physicians who participate in the Medicaid program.

ISMS negotiated with the Department to conduct additional orientation seminars at more convenient locations in the State for physicians and their staffs. ISMS also identified other problems in IDPA's processing of Provider Enrollment Applications and distributing MMIS claim forms to physicians' offices. ISMS discussed this problem at length with Department officials in order to provide immediate assistance to those physicians who had not received these materials. In October, the Society instituted a system of calling IDPA daily with the names of physicians who have not received the necessary MMIS materials. The ISMS Field Service staff will continue this system until the MMIS problems are completely resolved.

Many physicians have expressed interest in the information published in recent ISMS *Action Reports* and the July 1981 *IMJ* article entitled, "IDPA Implements MMIS." ISMS published the *IMJ* article to explain the technical aspects of completing the physician enrollment application and MMIS claim form. This effort was initiated by the Society because the explanations given in IDPA's Handbook were found to be unclear and difficult to interpret. Reprints of "IDPA Implements MMIS" can be obtained by contacting the Division of Professional Relations

EFFECTS OF BUDGET CUTS — Under the FY 82 Illinois State budget, IDPA is required to impose numerous cost containment measures on hospitals, physicians and allied health services to drastically reduce current IDPA spending. House Bill 811 is the legislation that provides for these cost containment measures. The hospital cuts under this bill are $106 million. The Department and the Illinois Hospital Association (IHA) engaged in formal negotiations to reach an agreement that would achieve the desired savings without the sanctions mandated by H.B. 811. The formula originally contained in this bill would have placed the vast majority of the cuts on the teaching hospitals. IHA has successfully negotiated a tentative agreement with IDPA which will spread the cuts out more equitably among all institutions. The financial pressures on hospitals to save Public Aid dollars will continue to occur in the coming fiscal year.

Physicians have also been affected by the budget cuts. In a notice dated October 1, 1981, IDPA announced plans to require prior approval from IDPA for selected inpatient surgical procedures and for more than one inpatient day prior to the date of a surgical procedure. ISMS began intensive negotiations regarding the content of this notice. ISMS officers and members of the Third Party Payment Processes Committee stressed the impracticality in Public Aid's creation of State bureaucracy performing functions similar to that of a PSRO. IDPA subsequently published another notice, dated October 21, 1981, modifying and clarifying the notice of October 1.

The October 21 clarification states that a physician wishing either to specify additional preoperative days, or to perform one of the listed surgeries on an inpatient basis should indicate medical necessity by a brief explanation and justification in the patient's medical record.

The Department also provided further clarification on the issue of "Patient Specific Orders". The clarification now specifies that: 1) Only tests specifically ordered by a physician will be reimbursed; and 2) Physicians must sign all applicable sections in the medical record for each test ordered.

A copy of the IDPA notice dated October 21 reflects the ISMS-IDPA negotiations on these issues. Please compare each of the IDPA Notices and review the major changes that resulted from the ISMS negotiations with the Department. Participating physicians should append the list of outpatient surgical procedures attached to the October 1, 1981 notice to the notice dated October 21, 1981, to eliminate any staff confusion.

If Illinois hospitals and IDPA find an agreed method to distribute hospital budget cuts, any requirement for physicians to document medical necessity for the designated inpatient surgical procedures or allowing more than one preoperative surgical inpatient day will be eliminated.

Participating physicians must understand that *the regulations promulgated in the October 21 notice are in effect until a notice by IDPA is published with different requirements.* ISMS will also keep you informed of future developments. The requirements for physicians to order and sign for all tests in the hospital are final and will not be changed as a result of the IHA-IDPA agreement.

MEDICARE — The recent changes in Medicaid claim processing have provoked physician inquiries to the Society regarding changes in the Medicare billing system. Earlier, EDS-Federal conducted training seminars in Illinois regarding Medicare's conversion to the AMA Universal Health Insurance claim form with the prospect of its implementation by October 1, 1981.

Illinois Medicare - Part B did not obtain approval from the Health Care Financing Authority (HCFA) arm of the Department of Health and Human Services because of the costs associated with printing, distributing, converting and processing the new claim forms. ISMS is monitoring this issue and will report to you on further developments as they become available. In the meantime, EDS will only accept the HCFA 1490 as the claim form for Medicare Part B services.

EDS-Federal has mailed a notice to physicians about the availability of the second edition of Medicare's Procedure Code Book. Physicians will find a wider and hopefully more accurate selection of procedure codes to use in describing the services that they provide to their Medicare patients. ISMS strongly suggests that physicians consult this updated edition and update their Medicare claims with the new procedure codes. Physicians who precode their Medicare claims will reduce the likelihood of carrier processing error. Physicians should also make sure that codes accurately correspond with the procedure narrative. Based upon the narrative, EDS-Federal (under its contract with HCFA) can change the physician's code to reflect their interpretation of available narrative. This change can increase or decrease reimbursement levels, depending upon the interpretation. Physicians who correlate accurate procedure narratives with appropriate codes should find fewer errors in processed bills.

CHAMPUS — Prior to mid-Summer, ISMS Field Representatives served as CHAMPUS/CHAMPVA representatives for Wisconsin Physician Services (WPS). Currently, WPS, the CHAMPUS fiscal intermediary in Illinois, is conducting their own field service activity for physicians who submit claims to CHAMPUS. The Illinois CHAMPUS representative is Marlene Woleske in Madison, Wisconsin at (608) 221-4711. ISMS will continue to assist its members in interpreting and clarifying CHAMPUS reimbursement policies. Please feel free to contact your ISMS Field Representative for assistance.

NOT TO CIRCULATE

NOT TO CIRCULATE